Agenda - Health and Social Care Committee

Meeting Venue:
Remote via Zoom
Meeting date: 27 January 2022
Meeting time: 09.00

For further information contact:
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In accordance with Standing Order 34.19, the Chair has determined that the public are excluded from the Committee's meeting in order to protect public health. This meeting will be broadcast live on www.senedd.tv

Private pre-meeting (09.00-09.30)

1 Introductions, apologies, substitutions and declarations of interest

(09.30)

2 Hospital discharge and its impact on patient flow through hospitals: evidence session with NHS bodies

(09.30-10.30) (Pages 1 - 54)

Nicky Hughes, Associate Director for Employment Relations - Royal College of Nursing in Wales
Dr Yvette Cloete, Clinical Director and Consultant Paediatrician - Grange University Hospital, Royal College of Paediatrics and Child Health
Dr Karl Davis, Vice-Chair - British Geriatrics Society

Research brief

Paper 1 - Royal College of Nursing in Wales
Paper 2 - Royal College of Paediatrics and Child Health
Paper 3 - British Geriatrics Society

Break (10.30-10.45)

3 Hospital discharge and its impact on patient flow through hospitals: evidence session with allied health professionals

(10.45-11.45) (Pages 55 - 70)

Dai Davies, Professional Practice Lead, Wales - Royal College of Occupational Therapists

Calum Higgins, Public Affairs and Policy Manager Wales - Chartered Society of Physiotherapy

Pippa Cotterill, Head of Wales Office - Royal College of Speech and Language Therapists

Paper 4 - Royal College of Occupational Therapists

Paper 5 - Chartered Society of Physiotherapy

Paper 6 - Royal College of Speech and Language Therapists

4 Paper(s) to note

(11.45)

4.1 Letter from Chair, Petitions Committee to the Chair regarding P-05-1078 Increase funding for mental health services and improve waiting times for people needing help in crisis. We need a change!

(Pages 71 - 72)

4.2 Response from the Chair to Chair, Petitions Committee regarding P-05-1078 Increase funding for mental health services and improve waiting times for people needing help in crisis. We need a change!

(Pages 73 - 74)

5 Motion under Standing Order 17.42(ix) to resolve to exclude the public from items 6, 7, and 9 of today's meeting

(11.45)

6 Welsh Government Draft Budget 2022-23: consideration of draft report

(11.45-12.05) (Pages 75 - 106)

Draft report

7 Business Committee review of committee timetable and remits: consideration of draft letter

(12.05-12.15) (Pages 107 - 118)

Paper 7 – draft letter

Lunch (12.15-13.00)

8 Hospital discharge and its impact on patient flow through hospitals: evidence session with NHS bodies

(13.00-14.30) (Pages 119 - 154)

Gill Harris, Deputy Chief Executive and Executive Director of Nursing and Midwifery - Betsi Cadwaladr University Health Board

Dr Anthony Gibson, Bridgend ILG Director - Cwm Taf University Health Board

Carol Shillabeer, Chief Executive - Powys Teaching Health Board

Jason Killens, Chief Executive - Welsh Ambulance Services NHS Trust

Paper 8 – Betsi Cadwaladr University Health Board

Paper 9 – Cwm Taf University Health Board

Paper 10 – Powys Teaching Health Board

Paper 11 - Welsh Ambulance Services NHS Trust

9 Hospital discharge and its impact on patient flow through hospitals: consideration of evidence received

(14.30-14.45)

Agenda Item 2

Document is Restricted

Royal College of Nursing Wales response to the Health, and Social Care inquiry into the Hospital Discharge its impact on patient flow through hospitals

The Royal College of Nursing Wales is grateful for the opportunity to respond to this consultation. The Royal College of Nursing Wales has confirmed our availability to provide oral evidence to the Health and Social Care Committee on the 27 January 2022.

The Royal College of Nursing Wales previously gave evidence on hospital discharge to the 5th Senedd's Health, Social Care and Sports Committee[1]. Since the evidence was given to the 5th Senedd Committee the hospital discharge process has not improved.

Summary

- There is not enough capacity or resources in the community or care homes to receive patients from hospital. This is a significant challenge to the health and social care sector and a pivotal reason why there are delays in transfer.
- There is a lack of consistent communication across professions and between health, social care and third sector organisation which adds to delays in hospital discharge.
- Hospital discharge became evermore so complex during the COVID-19 pandemic and care home are still struggling.
- Discharge liaison nurses are pivotal to ensure a smooth and effective discharge for an individual with complex needs.
- Clinical leadership plays an important part to ensure effective discharge occurs.

Recommendations

1. The Welsh Government should extend Section 25B of the Nurse Staffing Levels (Wales) Act 2016 to community nursing.
2. Health Education and Improvement Wales (HEIW) must develop a post-registration commissioning strategy with a focus on district nurses and community children nurses.

[1] Royal College of Nursing, 2020, Hospital Discharge inquiry evidence. HDP03 - Royal College of Nursing.pdf (senedd.wales)

3. NHS Wales should evaluate the 'Red Bag' scheme and assess how to improve communication across primary, secondary, community and social care.
4. The Welsh Government and NHS Wales must support and actively promote the role of the discharge liaison nurse.

Overview

NHS performance statistics in Wales show in February 2020 there were 448 delayed transfers of care (DTOC) with the majority of patients waiting on community care (202) or the availability/selection of care homes (97).[2] 67% of patients experiencing a delayed transfer of care were aged 75 or older. At the beginning of the pandemic reporting on DTOC was suspended, this has not resumed.

The acute hospital environment is not beneficial for people to remain in longer than clinically necessary. There is an increased risk of infection and a growth of mental dependency. Physical abilities decline rapidly which can result in an increased likelihood of falls and further injury and potential readmission to hospital.

The "Get Up, Get Dressed, Get Moving" campaign acknowledged that patients aged over 80 who remain in bed lose up to 10% of their muscle mass in just 10 days. The Campaign noted that up to 50% of patients can become incontinent within 24 hours of admission and fewer than 50% of patients recover to preadmission levels within 1 year[3].

The most significant factor causing delays in discharge is the lack of capacity in the community and care homes; there are not enough district nurses and care home nurses.

From hospital to home

Hospital to home refers to the care and support offered to patients that leave hospital for ongoing assessment and recovery with an aim of limiting unnecessary time in hospital settings.[4] From the hospital's front door to receiving care in the community, nurses are essential for delivering holistic care and ensuring a smooth patient journey. Hospital discharge is a multi-profession responsibility, but discharge liaison nurses are pivotal to ensuring a smooth transition for patients with complex needs.

Discharge liaison nurses

[2] Stats Wales, 2020, Delays in Transfer of Care, https://statswales.gov.wales/Catalogue/Health-and-Social-Care/NHS-Performance/Delayed-Transfers-of-Care/delayreason-by-localauthority

[3] Get up, get dressed, get moving, 2018, Cardiff and the Vale, http://www.cardiffandvaleuhb.wales.nhs.uk/get-up-get-dressed-get-moving

[4] Welsh Government, 2021, Delivering Home First, Delivering Home First (gov.wales)

The Royal College of Nursing recommends supporting the role of the specialist discharge liaison nurse. This is a specialist nursing role that is pivotal to ensuring that the discharge of patients *with complex needs* is effective and efficient.

Discharge liaison nurses:

- ensure patients with complex care can leave hospital as soon as it is appropriate
- provide expert advice and advocacy for the patient, relatives, carers and friends.
- ensures the patient has a safe and appropriate plan of care for when they leave hospital.
- provides a coordinating role and liaises between the patient, family members, inpatient staff, community nurses, GPs and social workers to ensure that all appropriate people are able to contribute to the ongoing plan of care.
- ensure a hospital bed is made available in a timely and planned way for the next person who needs it and avoids delays in Accident and Emergency.
- ensures the ward sister or charge nurse does not waste valuable time struggling to discharge a complex patient.
- ensures frontline nursing teams have the additional knowledge and skills necessary to plan ongoing care for patients with complex needs.

RECOMMEDATION: The Welsh Government and NHS Wales must support and actively promote the role of the specialist discharge liaison nurse.

Community care

Recovery from hospital-based treatment often requires clinical and social support. This package of care requires planning and of course the actual capacity to deliver it. In addition, some of our most vulnerable older people are supported 365 days of the year by community nursing teams, delivering complex care and treatment packages at home. If this package of care is interrupted by a hospital admission, there is a delay in restarting this process. In addition without adequate support the risk of readmission becomes higher due to falls, poor nutrition and infection.

For the last decade in Wales, health boards have reconfigured acute hospital services, reduced bed numbers, encouraged shorter patient stays, and enabled more complex treatments and care to be delivered at home. In A Healthier Wales (2018), the Welsh Government outlined its long-term vision: to shift health care provision from resource-intensive hospitals to community-based services. This combined with the ageing population, and increased comorbidity of illnesses, means community nursing services have been under high pressure.

Community nursing teams deliver care closer to home, promote independence and provide a holistic philosophy to care. Rather than focusing on a task-based approach

(e.g. changing a dressing), community nursing care is about a range of activities that assess and respond to the whole spectrum of needs of people being cared for in their homes and communities. This fits perfectly with the aspirations of A Healthier Wales.

Community nursing teams are led by district nurses. District nurses are the experienced pinnacle of a community nursing team, providing clinical supervision and leadership to the registered nurses and health care support workers.

However, despite increasing the number of patients and complexity of care provided in the community the number of district nurses has actually declined over the last decade. **10 years ago there were 749 FTE District Nurses working in the community. Today, there are only 635**. Today's data also needs to be taken with a pinch of salt as since 2016 health boards have miscoded nurses working in the community as district nurses, this has possibly inflated the number.

There is currently no strategy for post-registration nursing commissioning, including district nursing. As a result, the current commissioning figures for post-registration nursing education are not sufficient and will not facilitate the unique skills and knowledge needed to care for the population. This is having a devasting impact on hospital discharge.

Extend Section 25B of the Nurse Staffing Levels (Wales) Act 2016.

The Welsh Government should extend Section 25B of the Nurse Staffing Levels (Wales) Act 2016 to include community nursing services. Section 25B places a legal duty on health boards and trusts to calculate and maintain the level of nursing based on a specified methodology. The expansion of Section 25B to community nursing would support the discharge of patients in a timely manner into the community. It would further allow the patient to receive care in a more desirable environment and reduce hospital readmission.

RECOMMENDATION: The Welsh Government should extend Section 25B of the Nurse Staffing Levels (Wales) Act 2016 to community nursing. This would support the discharge of patients to the community in a timely manner

Child Community Care

Traditionally children's nurses were relatively few in number and hospital based. These days' children with complex health needs can receive far more care at home. This means many more children's nurses are needed in the community. Wound care & management, ventilation, BP monitoring, IV medication/line management, enteral feeding support and palliative care are some of the services children's nurses provide, along with vital education for other healthcare professionals and for carers and school

staff. Learning disability nurses are also in very short supply and are needed to support children and young people with challenging needs.

Most children nowadays with complex needs receive care in the community as do those recovering from treatment or operations. Despite this, there are few nurses in the community to specifically care for children with complex conditions.

The Royal College of Nursing Wales is pleased to see a rise in pre-registration children's nursing places for 2021/2022 but urges the Welsh Government to further invest in community children nurses to ensure care is available for children in the community.

The number of community children nurses failed to increase in 2020/2021 and, rather, decreased, falling from 48.7 to 43 (FTE). The Royal College of Nursing Wales is aware that there is a significant shortfall in the number of community children nurses needed to meet demand. Using the RCN's recommendation for a minimum of 20 FTE community children nurses per average-sized district with a child population of 50,000, Together for Short Lives estimated that Wales needs an additional 240 community children nurses.

RECOMMENDATION: HEIW must develop a post-registration commissioning strategy with a focus on district nurses and community children nurses.

Care homes

There are only 1,438 registered nurses working for commissioned care providers in Wales[5]

Effective rehabilitation and recovery takes time and extra care and assistance. This may be clinical e.g. wound dressing, pain management and monitoring infection. It may be assistance with daily living such as hygiene, toileting, and meal preparation. The mantra of 'people should be cared for at home' must be balanced with an understanding of whether the home environment is suitable. A home environment may be unsuitable because physical limitations that cannot be altered e.g. stairs, or there may be family arrangements that also require rearrangement e.g. if the recovering person is usually a full-time carer.

Following hospital treatment, it may be necessary for an individual to be placed into a care home as they are no longer able to live independently or their family can no longer provide the level of care the individual needs, this maybe a temporary or permanent placement in a care home.

The financial burden on the elderly patient and their families may delay the transition from the hospital setting into a care home facility of choice and suitability. Furthermore,

[5] SCW_workforce_profile_2019_Commissioned-Services_final_EngV2.pdf (socialcare.wales)

identifying a bed in a care home is a lengthy process and is often followed by a complex funding process.

- The time it takes have equipment provided e.g. temporary mobility aids
- The time it takes to make necessary adjustments and structural change e.g. a ramp
- The assessment for and availability of care packages to support home living e.g. nursing care
- The time taken to identify arrange and fund a suitable placement in a care home, where specific needs can be met.

In addition individuals with learning disabilities or a mental health diagnosis often experience a delay in discharge due to the lack of care providers available to provide the level of specialist care that the patient requires.

The discharge of a patient into a care home is an extremely complex process.

- The care home must assess the individual's needs, ensure the home can meet the needs of the individual through physical and staffing resources
- Discuss the choice with the person, family members and health professionals.
- Discharge needs to occur on an appropriate day for the care home
- If an individual needs to be transported to the home in an ambulance, that needs to be arranged , along with equipment.
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Communication between primary, secondary, community and social care

A significant barrier that contributes to delays in hospital discharge is a lack of consistent communication and joint working between health, social care and third sector bodies. Communication needs to be consistent and free-flowing throughout secondary, primary and social care.

Initiatives have been introduced to improve communication and hospital discharge across Wales. As part of the Integrated Care Fund, the Welsh Government implemented a "red bag" scheme across West Glamorgan in 2019-2020. It sort to meet the National Institute for Health and Care Excellence (NICE) Guidelines and helps care home residents admitted to hospital be discharged quicker. The bag contains key paperwork, medication, and personal items. This is handed to ambulance crews by care home staff when a patient need to be admitted to hospital. The bag travels with the patient from the care home to the hospital and back to the care home.

However, the scheme was only very recently introduced in West Glamorgan, and the COVID-19 pandemic disrupted any progress that could have been made.

RECOMMEDATION: NHS Wales should evaluate the 'Red Bag' scheme and assess how to improve communication across primary, secondary, community and social care.

The experiences of patients, families, carers and staff of discharge processes.

The importance of patient's experience has been recognised within the nursing profession and local health boards. *'Patient stories'* are often collected by nurses and used to illustrate an experience and reflect upon. The patient's story is shared with a group of nursing professionals with the aim to improve practices. Health board similarly gather patient stories and reflect upon them at their Board meeting, this is also done to improve practise.

The examples below are drawn from our members experience and illustrate some of the common concerns that we have explained elsewhere in the paper.

Example A – inappropriate early discharge

A patient who had been admitted to hospital for surgery was due to be discharged on a Saturday. She was instead discharged late on Friday and a surgical drain had been removed even though it was still draining. The wound leaked overnight, and the bedding had to be changed 3 times. By Monday she was sent back to hospital by her GP. Following her experience, she developed abdominal collection, wound infection and sepsis. The patient expressed that she waited hours for another bed to be available and was admitted for a further three weeks.

Example B – a delayed discharge

A patient who has undergone knee surgery was judged medically fit to be discharged on Wednesday. A physiotherapist was needed to assess mobility. The physiotherapist was able to see the patient on Friday. Some mobility aids were required for the home. Only an occupational therapist could issue these. The occupational therapist was able to see the patient on Monday and issue this equipment. An ambulance was booked to take the patient home on the Tuesday at 12noon. The patient was asked to leave the bed and sit in the discharge lounge at 9am so the bed could be free for another patient. A suitable wheelchair was found only at 11am. However, at this point there was no chair free in the discharge lounge so the patient remained in the bed. When the ambulance transfer team arrived at 12noon the patient's medication was not ready. The pharmacy advised the patient stay an extra night as the medication would be ready the next day. The ambulance transfer would need to be re-booked and the next available slot was Thursday. Thus, the total number of days delayed in hospital since the patient was ready for discharge was 7 days.

Example C- A mental health nurse discharge experience

Two individual patients, one had a learning disability and the other a mental health diagnosis, were awaiting a discharge from an assessment and treatment unit (AATU). Care providers had been agreed and went through the transition process and at times commenced their own care staff to begin shadow shifts with these individuals. The care providers then decided they could not meet the needs for these individuals The mental health nurse expressed that they find it extremely hard to deal with the failure to discharge as it leaves the most vulnerable patients back to square one in an AATU despite being ready for discharge and these instances have an impact on the patient's mental state which can cause a relapse.

About the Royal College of Nursing (RCN)

The RCN is the world's largest professional organisation and trade union of nurses, representing around 435,000 nurses, midwives, health visitors, healthcare support workers and nursing students, including over 27,000 members in Wales. RCN members work in both the independent sector and the NHS. Around two-thirds of our members are based in the community. The RCN is a UK-wide organisation, with its own National Boards for Wales, Scotland and Northern Ireland.

The RCN represents nurses and nursing, promotes excellence in nursing practice and shapes health and social care policy.

Related RCN Wales publications

- [1] Royal College of Nursing, 2020, Hospital Discharge inquiry evidence. HDP03 - Royal College of Nursing.pdf (senedd.wales)

- Royal College of Nursing Wales, 2021, *Paper 1: Community Nursing Teams The Role of the District Nurse and the Community Children Nurse*. https://www.rcn.org.uk/-/media/royal-college-of-nursing/documents/countries-and-regions/wales/2021/community-nursing-2021-english.pdf?la=en&hash=EC640EE9C2CAD03099C5933404613C68

- Royal College of Nursing Wales, 2021, *Nursing in Care homes*, https://www.rcn.org.uk/-/media/royal-college-of-nursing/documents/countries-and-regions/wales/2021/care-home-report.pdf?la=en&hash=C10E0200C2037FC64DDF34A3017ED78B

Royal College of Paediatrics and Child Health (RCPCH) response to Health and Social Care Committee consultation: Hospital discharge and its impact on patient flow through hospitals

About the RCPCH

The RCPCH works to transform child health through knowledge, innovation and expertise. We have over 500 members in Wales, 14,000 across the UK and over 17,000 worldwide. The RCPCH is responsible for training and examining paediatricians. We also advocate on behalf of members, represent their views and draw upon their expertise to inform policy development and the maintenance of professional standards.

Paediatric perspectives on hospital discharge and its impact on patient flow through hospitals

The scale of the current situation with delayed transfers of care from hospital.

Data would likely be held by Health Boards rather than by us as a Royal College, so for an accurate assessment of the scale across different parts of Wales, we would suggest requesting these data from Health Boards. However, we can provide a paediatric perspective based on members' clinical experience.

There are different experiences in various settings; for example between District General Hospitals (DGH) and the larger tertiary units. In DGHs there would typically be a fast turnover of patients and long waits for discharge are less common, although they do happen occasionally. This is often also the case in the larger tertiary units, however in these settings there is a greater volume of more complex cases where social care packages are often needed to enable discharge, which can lead to issues waiting for these. Member feedback suggests that in Cardiff, there would typically be around two 'longstay' inpatients most weeks in this situation.

The impact of delays in hospital discharge, both on the individual and the patient flow through hospitals and service pressures.

The delays in adults being discharged impacts on Paediatrics in that it can result in losing beds: this is something members have experienced.

Paediatricians see delays in CAMHS referrals from all types of paediatric units, which can have a significant impact both on services (if patients who are physically well are unable to leave paediatric units because there isn't a CAMHS place immediately available) and of course on the patient themselves who may be away from friends and family, or missing education or other types of support. In addition, a paediatric unit may not be an ideal location for young people in this situation, particularly if not set up for adolescents / teenagers.

When there are safeguarding concerns or CAMHS referrals, there is often a need for high staffing ratios. Close observation and additional support may be required, but this can be done in community or specialist settings. Hospital environments may not be ideal or appropriate.

The variations in hospital discharge practices throughout Wales and cross-border, and how they are meeting the care and support needs of individuals.

CCTH (Care Closer to Home) gets patients out quickly - these are community nurses that deliver intravenous antibiotics at home. However, this system is not in place in each Health Board. For example, members report that it is available and working well in Aneurin Bevan, but not available in Cardiff and Vale. There is therefore geographical inequity across Wales.

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

In many settings, paediatricians don't encounter the same barriers to discharge that adult colleagues often do in terms of care and support needs and in particular around housing and accommodation. However, in some settings, patients often need foster homes ahead of discharge, as well as health packages. There are added complications when there are social services and safeguarding needs. These may involve children who have experienced abuse, or who have complex needs and require specialist foster placements. In Cardiff, feedback from one of our members suggests that waiting for temporary foster carer placement is not an uncommon experience but is usually resolved within days rather than weeks.

CAMHS remains the biggest issue. Sometimes parents can't cope or need specialist placements. Paediatricians consistently report a significant increase in children and young people presenting as a result of mental health issues and perceive a substantial increase in referrals to specialist services over the past two years. Some of these children spend longer in hospital than is required. This can mean that children are medically fit for discharge but wait several weeks for a CAMHS placement.

There are other considerations in paediatrics:

- Once patient are discharged there can be delays whilst waiting for pharmacy medications; however this is usually hours rather than days.
- There can also be delays if family don't have transport, again hours rather than days.
- Occasionally there are delays if patients need to wait for an inpatient investigation or assessment, but this is not common.
- Chronic pain can cause delays if there are no adequate services to refer in to. An RCPCH member in Cardiff reported that it is not uncommon to have patients on the ward for over a month waiting for placements in Bath pain service.
- If a child is admitted for safeguarding investigation on a Friday, they may wait all weekend rather than the usual 24-48hrs required. This is partly due to problems in accessing radiology specialist investigations but also that no strategy meetings are held at weekends. This results in extended admission periods.

The support, help and advice that is in place for family and unpaid carers during the process.

In Cardiff and Value there is a discharge liaison service that provides support for families. Paediatricians have not reported concerns to us about support in hospital. There are third sector organisations offering support too. This is not universally replicated across Wales to the same extent.

What has worked in Wales, and other parts of the UK, in supporting hospital discharge and improved patient flow, and identifying the common features.

Paediatricians undertake regular reviews and discharge as soon as the child is well enough. Frequent ward rounds and close liaison with the NIC (Nurse in Charge) / PFCO (Patient Flow Co-ordinator) and others help. We have previously mentioned the CCTH (Care Closer to Home) programme which has been successful but isn't available throughout Wales; and the role of the Patient Flow Coordinators.

Members we have spoken to have identified a number of pieces of good practice which help, including:

- Clear plans documented with every patient contact from admission to ward rounds and reviews.
- Clear expectations discussed with family around criteria for discharge with realistic timescales so they can plan appropriately.
- Discussing transport with patients.
- Regular reviews with a view to discharge.
- Active management plans with clear instructions on criteria for review or discharge.
- Ward Week consultants (Consultant of the Week).

What 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 consideration of housing needs.

As highlighted above, the key changes need from a paediatric perspective are around delivering care and services closer to home in the community. These include foster services, CAMHS and pain management services as referenced previously. Delivering these services will require proper resourcing and developing the necessary workforce.

In addition to reducing waiting time for discharge, delivering effective community-based services could prevent hospital admissions in the first instance. This is acknowledged in – and is the direction of travel set out in - A Healthier Wales, the Welsh Government's long term plan for health and social care. We welcomed this plan when it was published, particularly in terms of its focus on delivering care in community settings close to people's homes; and on intervening early to prevent hospital admissions in the first place. We believe the focus should be on delivering these commitments by improving child health through early intervention and prevention; and resourcing services to deliver services in the right settings.

British Geriatrics Society
Improving healthcare for older people

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Russell George MS
Chair, Health and Social Care Committee
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15 December 2021

Dear Mr George,

Hospital discharge and its impact on patient flow through hospitals – Submission from the British Geriatrics Society

The British Geriatrics Society (BGS) welcomes the opportunity to contribute to the Health and Social Care Committee's inquiry into hospital discharge and its impact on patient flow through hospitals. The BGS is the membership organisation for all healthcare professionals engaged in the treatment and care of older people across the UK. Since 1947 our members have been at the forefront of transforming the quality of care available to older people. Our vision is for a society where all older people receive high-quality patient-centred care when and where they need it. We currently have over 4,500 members across the UK, including more than 200 in Wales.

Delayed discharge and the impact on older people

Most older people do not want to be in hospital and if they do need to be admitted to hospital, they want to be there for the shortest possible stay. However, this is not always the case, especially if there are new care requirements that need to be arranged to support discharge and onward care. We know that lengthy hospital stays are bad for older people as it puts them at risk of hospital acquired infections (including hospital acquired COVID-19) and deconditioning.

The BGS Wales appreciate the guidance published by the Welsh Government Delivering Home First Hospital to Home Community of Practice which has encouraged Health Boards to invest in care closer to home but there is still more to be done.

We know that there is a significant problem regarding the availability of social care in the community and this has an impact on hospital discharge and the length of time that people stay in hospital. This cannot be ignored – recruitment and retention of social care staff must be a priority to ensure that older people are able to access the care they need upon discharge.

It is however important to note that the entire patient pathway through hospital can impact discharge procedures and it is essential that planning for discharge begins at the earliest possible stage. Delays at the beginning of a hospital stay can have a direct impact on length of stay in hospital and the level of care someone requires when they leave. This can include a delay in getting to hospital in the first place or a delay in finding

a bed for a patient once they get to hospital which then causes a delay in accessing specialist care in hospital. It is therefore important to ensure that delays are minimised throughout a patient's hospital stay in order to enable to smooth discharge process.

Understanding hospital length of stay in Wales

We are using the example of hip fracture to demonstrate the impact of length of stay on older people across Wales. Hip fracture provides an effective metric with which to examine older people's experience as they pass through the complexities of the health and social care system. The diagnosis is very clear to define, and each hospital admits one or two patients each day, a quarter of whom are from care homes. These patients need collaborative care by a range of specialties and their rehabilitation and discharge depends on close cooperation within the hospital multi-disciplinary team and the between hospital and community services. While the relative ease of hip fracture diagnosis compared to patients with more complex conditions means that this is not directly applicable to all circumstances, we hope to demonstrate that by optimising hospital processes, length of stay can be reduced and discharge can be smoother.

Length of stay in Wales for hip fracture averages one month and with over 4,000 admissions a year, this means that at any one time this single condition leads to the occupation of 340 beds across Wales. Hip fracture provides a good example of the challenges facing older patients with frailty and the lessons from this condition can be applied to other conditions that older people present with when they attend hospital.

Variation across Wales

There is considerable variation in how long the same people stay as inpatients, depending on which Health Board is providing their care. Prior to the COVID-19 pandemic, this ranged from 27 to 34 days for people with hip fracture. The shortest length of stay was consistently achieved in Bronglais Hospital in Aberystwyth which has repeatedly been highlighted for the quality of its performance and outcome (including low mortality) in the National Clinical Audit of Hip Fracture.[1] This reflects the efficient and effective functioning of the local multidisciplinary team throughout the clinical pathway with reduced length of stay being just one consequence of properly coordinated multidisciplinary care.

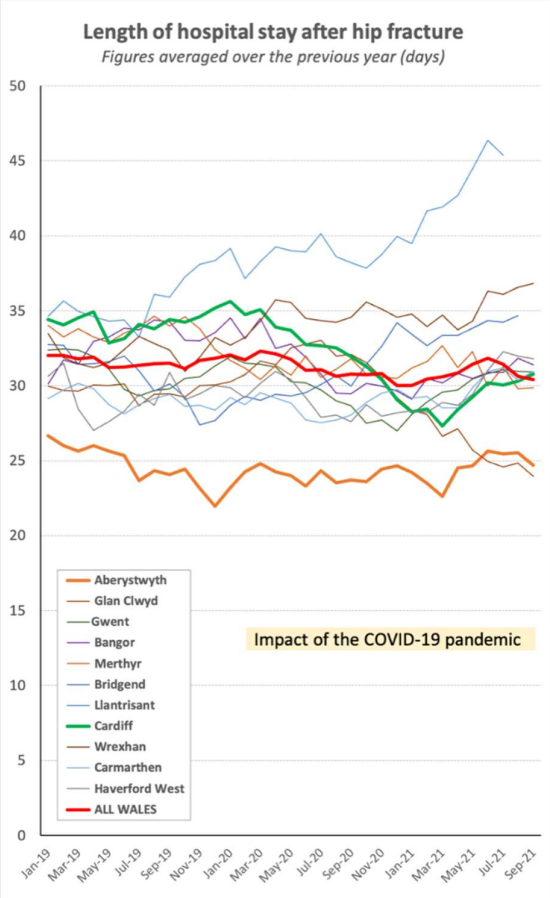
A natural experiment with length of stay in Wales

Since the onset of the COVID-19 pandemic, variation in length of stay has increased across Wales, and now ranges from 24 to over 40 days. The experience varies across health boards and some hospitals have reported significant improvements in length of stay while others have experienced increased problems.

At the onset of the pandemic, Cardiff and the Vale Health Board decided to improve capacity for COVID-19 activity by managing hip fracture patients more actively. It is important to note that there was not a decline in the number of people experiencing hip fracture during the pandemic. In Cardiff and Vale, geriatrician-led wards became the focus for intensive seven-day working by orthopaedic surgeons, nurses and therapists whose elective work had paused. As a result of efficient and effective joint working many more patients were able to mobilise promptly after surgery, unprecedented numbers of patients went home within a week and overall hip fracture length of stay fell by a week.

[1] https://www.nhfd.co.uk/

In contrast other hospitals where a similar approach has not been taken and geriatricians have been diverted to other parts of the hospital to care for COVID-19 patients, length of stay either lengthened or remained static during the pandemic. For example, Maelor Hospital in Wrexham took a different approach during the pandemic and experienced increased length of stay for their patients. It is also worth noting that the approach taken in Cardiff and Vale has not been sustained now that elective work has restarted. In order for this impact to be seen on a sustained basis, more permanent changes will need to be made to the organisation and staffing in hospitals.



Reducing length of hospital stay in Wales

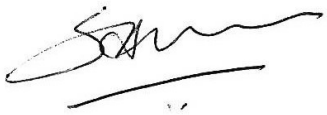
Discussions about length of stay tend to usually turn to delayed discharge, with many pointing to lack of capacity in social care as the cause of delayed discharge. It is important to note that this is the case for many people who have additional care needs at the end of their hospital stay. Current lack of capacity in the social care system means that there are often delays in arranging either care home placements or homecare packages for these people and this can result in them being stuck in hospital for longer than they medically need to be there. Lack of capacity in the homecare system can also mean that older people are not able to access the care they need in the community and are then admitted to hospital, often staying for longer than necessary while waiting for homecare to be arranged. Increased capacity in the community would help to avoid unnecessary hospital admissions.

However, by using the example of hip fracture services, we hope we have demonstrated that investment in efficient and effective multi-disciplinary working within the hospital

setting can also have an impact on length of stay and can reduce the need for additional care after hospital discharge.

We look forward to discussing these issues with you further when we give oral evidence to the Committee.

Yours sincerely,



Prof Sam Abraham
Chair, BGS Wales

Royal College of Occupational Therapists

Coleg Brenhinol Therapyddion Galwedigaethol

HSC(6)-09-22 Papur 4 / Paper 4

Written evidence to inform the Committee's inquiry on hospital discharge and its impact on patient flow through hospitals

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The Royal College of Occupational Therapists (RCOT) is the professional body for occupational therapy representing over 33,500 occupational therapists across the UK. Occupational therapists in Wales and work in the NHS, Local Authority social care services, housing, schools, prisons, care homes, voluntary and independent sectors, and vocational and employment rehabilitation services.

Occupational therapists work with people of all ages, who are experiencing difficulties through injury, illness or disability or a major life change. Occupational therapists consider the relationship between what a **person** does every day (**occupations**), how illness or disability impacts upon the person and how a person's **environment** supports or hinders their activity (PEO Model). Using this approach, we help people to continue or re-engage with participating fully in daily life, including work, social activities and maintaining roles and responsibilities.

Please find below comments from RCOT.

Submission

The scale of the current situation with delayed transfers of care from hospital?

RCOT have spoken to our members throughout Wales, and we have been informed that generally all our hospital based occupational therapists have delayed transferred of care patients on their caseloads and in one local health board they reported **every** patient that is deemed in need of a package of care is delayed.

The impact of delays in hospital discharge, both on the individual and the patient flow through hospitals and service pressures?

Our members report that some patients are discharged without – not always to family/informal care and run risk of their not coping/readmission. Some individuals have reported frustration/low mood from not being able to go home in a timely manner, even displaying challenging behaviour. The length of stay is psychologically hard for some patients as they cannot see family members very often. Wards do not run activities and so they are denied social interaction. For some patient groups this has a marked effect on their ability to rehabilitate and engage with staff. For our therapists this can be sole destroying as they are maintaining patients that have reached their full potential and should have left the ward, and are they are not providing rehab to new patients waiting to come in.

Members report other patients have become resigned to delays or are pleased that they are staying in hospital/being cared for by staff, but these behaviours risk increased dependency which then requires more support on discharge. Several of our members report that some patients are reluctant to be discharged and then assessed by social care agencies because of lack of trust. Specifically, that they will not be offered support.

Flow has been impeded, beds are full at all levels of acute and community hospital services.

More wards have opened for winter pressures and COVID leading to strain on existing staff resources, and no increase in occupational therapy staff/posts to cover. Our managers' report frustrations that they

are being asked to move staff away from services that stop admission and keep people at home to focus on hospital discharge. One manager explained that it's just like an added extra tap to a bath that is already overflowing.

The variations in hospital discharge practices throughout Wales and cross-border, and how they are meeting the care and support needs of individuals?

Most areas of Wales have different types of stay at home/return home/ home first services. Discharge from hospital services is based on Discharge to Assess to Recover principles. Primarily these services have been set up to enable provision of social and medical care at home rather than transferring to hospital but also to offer timely discharge to patients needing hospital care.

The D2AR model is already well-established in some areas and has significant implications for service delivery and has impacted upon the working arrangements for occupational therapists and other health professionals in both acute, community and local authority settings. The Discharge to Recover then Assess model can only be achieved through close partnership working. Our members report quite significant variation throughout Wales in how Occupational therapists and our AHP colleagues are used in each of the 4 D2RA pathways. For example, in CTMLHB (Stay well at Home) and in North Wales (home first) occupational therapists and other AHPs are situated in A & E departments. In 2019/20 the Stay Well at home service stopped 2,153 admissions of patients between the ages of 61-74 in 2018/19 only 183 avoided admissions. Although our members support local decision making it is frustrating where models of good practice are not replicated throughout Wales.

Several members are unfortunately reporting that they feel that because of the obvious pressures on the system, normal procedures are not being followed. Some district general hospitals are discharging into the community without the appropriate support at times, due to their own pressure. However, this does mean the community teams have to pick up the concerns when people get home and feel they cannot cope. Certain hospitals have a worse reputation than others for this practice.

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

Our member report time contrasts in being involved with assessment of individual's needs and capabilities regarding personal and simple domestic tasks. Our occupational therapists are in a good place to highlight concerns as to an individual's ability to cope without care and support. Although occupational therapists are completing assessments and making recommendations, but at times their voice is not always heard, and care is being sought in addition anyway in some cases. Our Social Care occupational therapists are reporting at times of an over prescription of services and equipment because assessments are rushed and are inclined to over prescribe to managed perceived risks. For example, one lady who one of our members seen, was told she needed a package of care of four calls a day to go home by the nursing team. She would be waiting four weeks in hospital for that, and she was main carer for her husband with dementia at home. She did need some help but with detailed conversations with her and her son, he agreed to move up from London to support her to come home until care could be put in place. She got home two days later and could be with her family where she wanted to be. Without an occupational therapy assessment to unpick what home meant to her and what was most important, and who could step in to provide that support, she would still be waiting for a package of care in hospital.

Pressure points are at the front door and back door (delays due to packages of care/support on discharge). When hospitals have a concerted effort to improve flow by focussing staffing in specific areas (extras working on weekends that may generally work 5 days per week) then pressure shifts. As previously mentioned, systems already in place to deal with this are struggling with re-deployment and lack of resources.

We have significant recruitment issues employing occupational therapists in our local authorities. Social Care occupational therapy waiting lists are substantial in most areas. Councils are losing occupational therapists to the NHS because of better wages and conditions.

Some people arrive in hospital much worse off due to lack of activity and lack of access to community services/GPs since the onset of COVID 19. They haven't sought help soon enough for preventative measures. Occupational therapists are seeing people with greater complexity of needs requiring higher intensity of intervention.

All areas of Wales report pressures on equipment services due to difficulties with supplies. If provision is needed for discharge this can also cause delays at present. There are major delays with moving and handling and assisted equipment.

The support, help and advice that is in place for family and unpaid carers during the process?

Our members feel at times there is too much pressure on family to provide support to help with discharge and this can be short lived/not sustainable. Some family members are not feeling prepared for a greater caring role. Some may have agreed to fill the gap in the past but now fear being let down and left to cope so decline in first place. Some patients fear being removed from waiting lists for a formal care package or moved down the list of priority even when family only agreed to do this as a temporary measure.

What has worked in Wales, and other parts of the UK, in supporting hospital discharge and improved patient flow, and identifying the common features?

The stay well at home service in CTMLHB and other services such as home first in Monmouthshire are excellent examples of practice that are keeping people away from hospital or discharge home quickly. It is hugely frustrating to our members that theses service are fragmented and generally funded on a short-term basis.

Common features

- Occupational therapists and other AHP's are positioned at the front door of services. AHP's can help avoid admission in the first instance if located in A&E, GP surgeries and with our paramedic colleagues
- Occupational therapists are key leaders in the service and are crucial to the successful delivery of D2AR pathways as they are experts in rehabilitation and reablement and already operate within acute, community, social care, housing and voluntary sector settings
- When Careful consideration is given locally to the capacity of the occupational therapy workforce to deliver the D2AR model, including mapping of existing acute, community and social care therapy services to identify staffing and skills mix, including gaps and pressures
- Our social care occupational therapist is part of the review of care packages - this can ensure the best ongoing level of support and can release cover for new service users. Our single-handed care programmes in large parts of Wales have reduced care and freed equipment for others

- Effective communication across teams and settings is essential to ensure that handovers take place effectively, that staff capacity can meet demand, and that all respective areas of responsibility are understood

What 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 consideration of housing needs?

- Increased Occupational Therapy/Social care services across the board
- Increase in formal carer services available to provide care packages for Reablement and long-term need
- Better access to GP services and increased capacity including occupational therapists working in GP practices
- Improvements to access to supportive equipment/advice including a better system for out of area requests (currently coming to hospital occupational therapy duty for administration)
- Therapists, nurses, and medics in acute settings can sometimes feel concerned about perceived risks of patients being discharged sooner. The RCOT document *Embracing risk; enabling choice* (RCOT, 2017) can support conversations and decisions that focus on positive risk taking.

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Date 12/01/22

Dear Colleague

Re: Health and Social Care committee, written Evidence for patient discharge inquiry

Introduction

The CSP welcomes this opportunity to respond in writing to Health and Social Care committee request for our views patient discharge.

Our written briefing compliments the principles in 'A Healthier Wales' and, the stated aim of the Welsh Government, to "whole system approach to health and social care, which is focussed on health and wellbeing, and on preventing illness."

Thank you for providing us with an opportunity to highlight the current state of play in patient discharge services, while offering comment on specific areas which we see the physiotherapy and the profession making a positive contribution to better patient outcomes.

Comments from the CSP

Discharge and waiting time link

Waiting times and discharge times are interlinked, and physiotherapy waiting times relate strongly to discharge from other services such as orthopaedics. When a patient is discharged from hospital, physiotherapy is key in meeting the rehab needs of the patient, ensuring effective outcomes and reduction in relapses of the condition they were treated for. Rehab is key for effective discharge and every patient in wales should receive a consistent service. The priority in recent years is to deliver as much of this at home and in the community as possible.

Physiotherapy waiting times are linked to the number of patients being discharged from hospitals. The increase in physiotherapy waiting times reflects the increase in patients being discharged as they move through the treatment pathways.

We hear from our members that the workforce issues in social care has an impact on discharge and the length of stay of patients in hospital.

Right to Rehab

The Right to Rehab is about creating the expectation that patients and citizens in Wales should have rehabilitation services as a matter of course. It's about the delivery of rehabilitation services to everyone that needs it. It complements the Healthier Wales strategy and does not require legislation, just a commitment to delivery of rehab services.

Rehabilitation helps people do more than just survive their condition – it helps them really live. It is vital to people living with long-term physical or mental conditions or recovering after an accident, operation or illness, in order they can live as well - and as independently - as possible. In most cases people's rehabilitation will require a period of intervention by health and social care professionals. It will also often extend beyond that treatment and into long-term support within communities. At that point rehabilitation can take many forms, and is determined by people's needs and their goals.

Currently these needs are not being fully met: while there are excellent examples of rehabilitation, it is not consistently available. Services are not joined up between acute, residential and home settings, so people can easily be lost to the system. Where people can access services, they often have to wait too long, usually at just the time when rehabilitation would be most effective. Without the rehabilitation they need, people are at risk of readmission to hospital, likely to need repeat visits to GPs, need additional care from their family or providers, and may struggle to return to work or live their lives to the full.

Multi-disciplinary working (MDT)

Effective discharge usually delivered by multi-disciplinary teams. The CSP can provide examples of good multi-disciplinary working that has been accelerated during the pandemic. As ever, the issue is cross Wales learning and consistency of delivery.

Patients can be broadly categorised into 4 main groups, and require different levels of rehab on discharge.

1) Acute Covid patients who need considerable rehab due to the virus, including long Covid.
2) People who have not received treatment during the lockdown but will enter the health system when it's safe, currently self-managing their conditions.
3) Patients who are entered the health care system late, having missed early diagnosis or waited longer for treatment.
4) People who have deconditioned during isolation.

All these groups of patients have become more complex, both medically and socially. There is less support available in the community and therefore the burden on the health and social care services has increased.

Our members tell us that many more patients are accessing self-managing resources. The increase can be seen in patients who are digitally aware and with high engagement with their health services. However, his type of resource cannot cover all patients, particularly those with no digital skills or in digital poverty.

Physiotherapy capacity

In short, Physiotherapy services are stretched at capacity, even after adapting services to increase the number of patients self-managing and getting advice virtually. Our main concern is that

physiotherapy services are at capacity, before everything has come back to full throughout the healthcare system.

Examples of good adaptation are the increased use of self-management resources available, including dedicated websites such as "keeping me well" in Cardiff and the Vale Health Board: https://keepingmewell.com/what-is-physiotherapy/what-is-musculoskeletal-out-patient-physiotherapy/ . As mentioned above, these resources assist a great many people, but cannot be a catch all.

Loss of space and moving to virtual

Loss of space in hospitals is effecting ability of physiotherapists to see patients face to face. Rehab spaces in hospitals were commandeered during the pandemic, sometimes for non-clinical use, and it's proving to be difficult to get them back for clinical use.

While we support the move to community service delivery, there is still a need for space for patients to rehab before discharge. For example, space to rehab a stroke patient before discharge is vital to get them in a safe condition to be discharged. Where dedicated space is no longer available the rehab is being delivered at the bedside.

Examples of space lost include:

- Hydrotherapy pools still closed
- Gyms taken for PPE storage
- Ward rehab space
- Staff wellbeing areas not returned

On discharge patients should be able to pick from a menu of services, including face to face or community activities. While we support the increase in virtual provision, being virtual is not as time saving as may be perceived. Often, digital set up with a patient takes more time, while virtual engagement is one –to-one, and is more time consuming for the staff than delivering community classes or

Innovation in the way of joint working in leisure centres is welcome, although has become a challenge. As many of the centres are used as vaccination centres and therefore the space isn't available to deliver in the community. Discharge of patients and avoiding readmission is most effective when rehab services work with NERS to continue the benefits of exercise and rehab. This has been a challenge for local authorities during the pandemic and we hope this can be addressed longer term.

Solutions

Increased use of prehab

Prehab has the benefits of preparing patients for their treatment and increasing the outcomes on discharge. As an example BCUHB has engaged joint approach Rehab Ltd to offer prehab to long wait knee patients:

> "This will be a collaborative piece of work delivered by BCUHB and Joint Approach Rehab Ltd. The pilot will first align a prehabilitation programme to the needs of long waiters on the stage 4 (waiting over 52 weeks) knee orthopaedic pathway. For the identified cohort of long waiters, an innovative technological solution to prepare patients for surgery will be delivered, promoting independent management of their condition in their home environments. It will include evidence-based education and exercise programmes combining expertise from

Physiotherapy, Psychology, Nutrition and Strength and Conditioning in a single integrated package. The information within the programme will enable patients to personalise their approach to their pre-habilitation and transform the way in which BCUB prepare their patients for arthroplasty surgery."
Source BCUHB FOI response to the CSP and Versus Arthritis Cymru.

Innovative models such as this should be commonplace across Wales and will increase the number of patients being discharged successfully without further need for treatment.

General Multi morbidity rehab services
Many patients have comorbidities requiring several types of rehab on discharge. This multiplication of service requirements could be streamlined by providing multi-morbidity rehab services, allowing one waiting list and one point of contact for the patient being discharged.

Evaluation
At some point an evaluation of the changes made in the pandemic will show whether changes to virtual working improved outcomes for patients. The necessity of change at the time is recognised by the CSP, however taking stock of the long term changes to service delivery is becoming increasingly important as time goes on.

Increased presence of Physiotherapist and AHPs in primary Care
After discharge and rehab patients will generally wish to self-manage their conditions using resources and occasional expert advice. The most convenient and accessible location for further advice is in primary care. Increasing the workforce in this setting over the longer term will benefit the wider health service and help in the preventative side of health care.
First Contact Practitioners already work in primary care, and are trained to an advanced level to be the first point of contact for a patient in a GP surgery. Many have been funded on transformation or pilot project money across Wales. A more consistent and sustainable funding source would expand this workforce and provide GP surgeries with advanced practice skills. Investing in this workforce will alleviate pressures elsewhere, including readmissions.

About the CSP and Physiotherapy

The Chartered Society of Physiotherapy is the professional, educational and trade union body for the UK's 58,000 chartered physiotherapists, physiotherapy students and support workers. The CSP represents 2,400 members in Wales.

Physiotherapists use manual therapy, therapeutic exercise and rehabilitative approaches to restore, maintain and improve movement and activity. Physiotherapists and their teams work with a wide range of population groups (including children, those of working age and older people); across sectors; and in hospital, community and workplace settings. Physiotherapists facilitate early intervention, support self management and promote independence, helping to prevent episodes of ill health and disability developing into chronic conditions.

Physiotherapy delivers high quality, innovative services in accessible, responsive and timely ways. It is founded on an increasingly strong evidence base, an evolving scope of practice, clinical leadership and person centred professionalism. As an adaptable, engaged workforce,

physiotherapy teams have the skills to address healthcare priorities, meet individual needs and to develop and deliver services in clinically and cost effective ways. With a focus on quality and productivity, physiotherapy puts meeting patient and population needs, optimising clinical outcomes and the patient experience at the centre of all it does.

Senedd Cymru Health and Social Care Committee consultation on Hospital Discharge and its Impact on Patient Flow Through Hospitals

Executive summary

The Royal College of Speech and Language Therapists (RCSLT) Wales welcomes the opportunity to provide written and oral evidence as part of the committee's inquiry on hospital discharge and its impact on patient flow through hospitals**.** Our response focusses on the key themes raised within the terms of reference and is based on discussions with our members across Wales.

Key points

- Our members report the main barriers and pressure points include capacity limitations within social care to support frail elderly patients in the community and across reablement services.
- Ongoing issues with regards to the nursing and the health and social care workforce is impacting on the ability to deliver speech and language therapy interventions in some areas as speech and language therapists (SLTs) are required to support ward staff with fundamentals of care. It is vital that Allied Health Professionals (AHPs) are protected from redeployment given their central role in enabling people to live well at home.
- A focus and investment in rehabilitation and community support programmes is also essential to effectively support the 'home first: discharge to recover and assess' pathway. There are positive discussions with regards the AHP role within primary care model but sustained funding is required.
- A strong recurrent theme from some health boards was that the need for neurorehabilitation was a significant contributory factor for patient delays, with patients sometimes experiencing protracted lengths of stay. Focus and investment in this area is required.

About the Royal College of Speech and Language Therapists

1. RCSLT is the professional body for speech and language therapists, SLT students and support workers working in the UK. The RCSLT has 17,500 members in the UK (650 in

Wales) representing approximately 95% of SLTs working in the UK (who are registered with the Health & Care Professions Council). We promote excellence in practice and influence health, education, care and justice policies.

2. Speech and language therapy manages the risk of harm and reduces functional impact for people with speech, language and communication support needs and/ or swallowing difficulties.

3. As part of emergency care and discharge planning, SLTs work closely with other services, such as physiotherapists and occupational therapists, to assess and support patients' needs. They help to prevent a cycle of emergency readmissions by working with individuals and their families to develop personalised strategies to manage their speech, language, communication and swallowing difficulties. For example, they develop feeding plans and daily exercises that patients can follow at home and that community-based staff can supervise. By developing personalised care plans, SLTs can help patients to understand their own health needs and support them to feel safe and confident when they return home.

The scale of the current situation with delayed transfers of care from hospital.

4. Our members report that there are significant numbers of patients in acute hospital beds who are medically fit to leave hospital but who are currently unable to be discharged due to the lack of carers in the social care system. There is sustained demand and pressure in hospitals due to a combination of factors including the need to increase non-Covid activity whilst there continues to be sustained high level of Covid circulating in the community resulting in hospitalisations and self-isolation for the workforce. Ongoing issues with regard to the nursing and the health and social care workforce are impacting on the ability to deliver speech and language therapy interventions in some areas as SLTs are required to support ward staff with fundamentals of care. Length of stay is also impacted significantly by difficulties in securing care packages for patients who need them. In some hospitals pressure is so acute that we understand that senior leadership are considering closing/de-escalating non urgent services and redeploying staff.

The impact of delays in hospital discharge, both on the individual and the patient flow through hospitals and service pressures.

5. From a system perspective, members report that delayed discharges impact on the number of beds available for admitting patients leading to longer waiting times in accident and emergency departments or cancellations of planned admissions. There is daily pressure on beds with the need to expedite discharge of transfer from acute to rehab sites. This affects the AHP workforce including speech and language therapy who have to prioritise patients who need discharge. Wards have also been re-configured to meet the needs of the patients admitted. For example, Covid vs non-Covid beds.

6. For individual patients, many of whom are over the age of 65, discharge delays can lead to poorer outcomes through the loss of independence, confidence and mobility, as well as risks of hospital acquired infections, re-admission to hospital or the need for long-term support.

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

7. Our members report that the main barrier for many services is the lack of capacity within the social care system to support frail, elderly patients in the community and the ability of social care carers to modify diet and/or fluids to enable people to return home safely.

8. Another key factor affecting discharge is the limited capacity within community rehabilitation services in some areas. Community rehabilitation services may be defined as;

   'assessment, advice and tailored rehabilitation support that takes place in settings outside of acute hospital wards and that improves people's health and wellbeing. Community rehabilitation helps people with long term conditions, injuries or illness to live well for longer[1].'

   Rehabilitation cuts across the health and social care systems supporting people in different settings, and often reducing the need for care and hospital admissions. It supports recipients to remain as independent as possible and participate in education, work, family life and their community and society as a whole. Community rehabilitation can improve recovery rates from illness and injury and thereby limit the level of social care needed after discharge from hospital. Community rehabilitation can also enable people to better self-manage their long-term conditions and slow the impact of degenerative diseases, both of which create knock on savings for social care budgets.

9. Our members tell us that despite the impact of high-quality rehabilitation on quality of life and long-term NHS and social care costs, community rehabilitation is often piecemeal and varies significantly depending where you live in Wales. In many cases, patients are only being referred to speech and language therapy for crisis management and there are missed opportunities to engage in advanced care planning and active treatment.

10. Our members have commented that often, community care packages do not provide the communication support required (in terms of numbers of hours needed for intervention, education and support by SLTs) as the capacity for independent living dwindles. These packages frequently do not recognise the need for older people to have adequate communication abilities and the need for adequate nutrition if swallowing is compromised. This also increases the demand on family members who also require support and education as how to best assist the older person to maintain the best functional ability at home. This situation is exacerbated by the impact of shielding and social isolation as a result of the pandemic.

11. These concerns about the availability of community rehabilitation provision are echoed in two recent reports by Senedd cross party groups. A 2020 report from the Stroke Association, based on evidence collated as part of the Stroke Cross Party Group inquiry, revealed that 21% of stroke survivors in Wales reported that they did not receive enough support after a stroke[2] with only a minority of stroke survivors receiving therapies at

[1] Community Rehabilitation Alliance (2020). Live Well for Longer. Available here

[2] Stroke Association (2018), Lived Experience of Stroke - Chapter 4 Rebuilding lives after stroke, 2018. Available: https://www.stroke.org.uk/sites/default/files/leos_one_pager_wales_chapter_4.pdf

guideline levels[3]. The report recommends that 'Health boards must take immediate steps to improve their therapy provision and bring delivery of therapies closer to RCP guidelines.'[4]

12. The Wales Neurological Alliance has also recently undertaken an inquiry into the impact of the Welsh Government's neurological delivery plan. The report recognises that there has been investment in neurological rehabilitation but highlighted that there remain low levels of availability of community services stating;

    'Many poor experiences were described by contributors, in particular in relation to a lack of availability of community-based services such as physiotherapy, speech and language therapy, occupational therapy, continence advice and support, services that help people to be physically active, mental health services and emotional support. '[5]

13. We welcome the drive towards integration and an increasing focus on moving services closer to home. We are pleased to have recently joined the AHP leadership group for the Strategic Primary Care Programme. A number of speech and language therapy services have been able to benefit from monies under the Integrated Care Fund (ICF) with the aim of supporting those with swallowing and communication difficulties to keep safe and well at home including within care-home settings. However, funding streams such as the ICF are often very short-term which can lead to recruitment challenges. The AHP Framework for Wales recognises that;

    'too often, short term innovations in the AHP services have been established as pilots without long term sustainable funding in place. This has limited the opportunity to scale up and support wider adoption across Wales when innovations as detailed above are proven to be effective'[6].

    We strongly recommend that those interventions that deliver high value outcomes are identified and adopted across Wales to improve community rehabilitation services as a key enabler in supporting discharge and reducing hospital admissions. A focus and investment in rehabilitation and community support programmes is also key to the implementation of the 'home first: discharge to recover and assess' pathway.

14. A strong recurrent theme from some health boards was that the need for neurorehabilitation was a significant contributory factor in patient delays, with patients sometimes experiencing protracted lengths of stay.

15. Specialist rehabilitation services play a vital role in the management of patients admitted to hospital by supporting patients after their immediate medical and surgical needs have been met, and maximising their recovery and supporting safe transition back to the community. As our population continues to grow and life expectancy increases, the number of people with a neurological condition will continue to rise. Neurological conditions vary widely in terms of their impact; they include progressive, incurable conditions, stable conditions, and

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[4] Stroke Cross Party Group (2020). The Future of Stroke Care in Wales: report of the inquiry into the implementation of the Welsh Government's Stroke Delivery Plan.
[5] Cross Party Group on Neurological Conditions (2020). *Building the foundations for change: The impact of the Welsh Government's Neurological Delivery Plan*

[6] Welsh Government (2019). Allied Health Professional Framework for Wales. Available here: https://gov.wales/sites/default/files/publications/2020-02/allied-health-professions-framwework-for-wales.pdf

also sudden-onset neurological incidents that can severely affect a person's life. The complex nature of these conditions means that professionals require specific expertise and training to diagnose and manage them, the specialist care enables the provision of expert knowledge, tailored care planning, care integration and multidisciplinary working. Failing to access specialist care can lead to poorer outcomes for people affected by neurological conditions and put pressure on other parts of the health and social care system.

16. Specifically, it has inferred by members that the lack of inpatient neuro rehabilitation beds (level 2) means that provisioning the rising demand for inpatient neuro rehabilitation is very challenging. As a result patients may experience substantially delayed transfers of care in acute hospitals due to waits in accessing inpatient neuro-rehabilitation.

What has worked in Wales, and other parts of the UK, in supporting hospital discharge and improved patient flow, and identifying the common features.

17. We wish to highlight a number of developments of interest which relate to our view of the whole-system approach which is required to improve patient flow, maximising the usage of AHPs.

<u>Sandwell and West Birmingham Trust's 'rapid response therapy team'</u>

SLTs play a crucial role in Sandwell and West Birmingham Trust's 'rapid response therapy team'. They work alongside other AHPs and attend A&E to:

- prevent unnecessary hospital admissions, via a highly responsive service that operates 12 hours a day, 365 days a year to assess patient needs.
- work collaboratively with social work colleagues to support the patient to return home.
- deliver urgent speech and language therapy assessment within three hours in community, to ensure patients' swallowing can be managed at home by community staff.

SLTs have helped to reduce costs and improve patient outcomes at the Trust by providing intensive therapy to ensure patients start eating and drinking as soon as possible to avoid the use of tube feeding and allow a safe return home with community speech and language therapy support. As part of an integrated care approach, they also work closely with the discharging and community teams to ensure patients identified as at risk of readmission receive appropriate support in the home setting, and are psychologically and physically prepared to return home. The Trust's integrated care service has helped to relieve winter pressures on A&E services and create financial savings and improved outcomes for patients. As a consequence, it has reduced hospital admissions by 2,478 per year, reduced length of stay in hospital from 10 days to seven days, and saved approximately 17,000 bed days, which has the potential to reduce costs by more than £7 million.

<u>Cardiff and Vale University Health Board SLTs at the front door at A&E</u>

Attending an emergency department is associated with a high risk of admission for older people, who are admitted to hospital more frequently and then stay in hospital longer than other patients. Having SLTs at the 'front door' of A&E departments enables them to make rapid interventions to ensure that people are admitted to hospital only for urgent medical care. During the integrated

therapy project which spanned 3 months, the following outcomes were achieved thus demonstrating the need for and benefits of speech and language therapy input prior to admission to the ward.

- **17** admissions were prevented in the Assessment Unit (AU), which were led by SLT. Close liaison with the Community Resource Team SLT Team was essential, as they could provide support on the day of discharge.
- **67** chest infections prevented by SLTs in AU, saving **£102,912.**
- A review of length of admission for those admitted with a chest infection was undertaken for the second month of the project. The mean length of stay was 5.8 days. If this were to be the average for the year this would represent an additional cost saving of an average of 8.4 bed days saved per person which would equate to a saving of **£20,508.**
- The projected annual saving would be **£998,748.**

What 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 consideration of housing needs.

18. Delayed transfers of care are multifactorial so no single intervention will provide overall success. A whole-system approach is needed. AHPs' skills are required in order to help people remain at home, at the front door of hospitals, supporting timely discharge and enabling successful transitions back into the community. Professor David Oliver, Visiting Fellow from The King's Fund has stated that

    *'*AHPs are critical in getting patients back to their own home quickly form the front door of the hospital and ensuring good inpatient rehabilitation and discharge planning.*'*[7]

19. The RCSLT firmly believes that multidisciplinary admission and discharge teams across the hospital environment should include SLTs, with therapy led discharge planning for people with complex health care needs. When planning the configuration of services, it is vital to ensure that the right professionals with the right skills are employed to meet the needs of the local population.

20. We are concerned at reports that redeployment of AHPs is once more being considered to bolster workforce challenges with regard to nursing and health care support workers, particularly given the importance of AHPs to successful discharge planning.

21. During the first wave of the COVID-19 pandemic, the RCSLT supported appropriate redeployment of SLTs into other roles. Our members were keen to volunteer at this time of national crisis. However, 21 months later we have seen the impact that the pandemic, including this period of redeployment, has had on speech and language therapy services and the people who rely on them. Given these risks, we do not support the redeployment of SLTs away from services that are already under extreme pressure as they attempt to restore services, reduce waiting lists and meet targets. We believe that there are more cost-effective alternatives that have been used successfully in some areas and could be used more widely, for example bringing back retired staff or using volunteers or students to increase system capacity.

    Further information

[7] https://www.kingsfund.org.uk/about-us/whos-who/david-oliver

22. We hope this paper will be helpful in supporting the committee discussions around discharge and patient flow. We would be happy to provide further information if this would be of benefit. Please see below our contact details.

Confirmation

This response is submitted on behalf of The Royal College of Speech and Language Therapists in Wales. We confirm that we are happy for this response to be made public.

Y Pwyllgor Deisebau

—

Petitions Committee

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Russell George MS
Chair
Health and Social Care Committee
Tŷ Hywel
Cardiff Bay
CF99 1SN

2 December 2021

Dear Russell

Petition P-05-1078 Increase funding for mental health services and improve waiting times for people needing help in crisis. We need a change!

The Petitions Committee considered the above petition at our meeting on 15 November, alongside correspondence from the Deputy Minister for Mental Health and Wellbeing and the Petitioner.

At the meeting members noted that it will take time to establish and to embed the Welsh Government's approach to provide 24 hour appropriate response and pathway to support. Members therefore agreed to write to you in order to request that the petition and correspondence is included in any future scrutiny work regarding mental health services.

Further information about the petition, including related correspondence, is available on our website at: https://business.senedd.wales/ielssueDetails.aspx?IId=35006&Opt=3.

If you have any queries, please contact the Committee clerking team at the e-mail address below, or on 0300 200 6454.

Yours sincerely

Jack Sargeant MS
Chair

Croesewir gohebiaeth yn Gymraeg neu Saesneg.

We welcome correspondence in Welsh or English.

Y Pwyllgor Iechyd a Gofal Cymdeithasol
—
Health and Social Care Committee

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Jack Sargeant MS
Chair
Petitions Committee

14 January 2022

Dear Jack

Petition P-05-1078 Increase funding for mental health services and improve waiting times for people needing help in crisis. We need a change!

Thank you for your letter dated 2 December 2021 regarding the above petition, in which you asked the Health and Social Care Committee to consider this petition and associated correspondence in any future scrutiny work regarding mental health services.

Priorities for the Sixth Senedd

As a member of the Health and Social Care Committee, you will be aware that mental health and tackling the waiting times backlog were priority areas emerging from our consultation on the Committee's priorities for this Senedd. We subsequently identified both matters in our strategy for the Sixth Senedd as priorities for consideration within the first year of this Senedd.

Mental health inequalities

In line with our strategy, we launched an inquiry into mental health inequalities on Monday 10 January. We will be looking in particular at which groups or communities are most likely to be disproportionately affected by poor mental health, what barriers they face in accessing services, whether current policy sufficiently addresses these issues, and what further actions might be needed to improve mental health and outcomes, and reduce mental health inequalities in Wales.

Further information regarding this inquiry, including details of how to submit written evidence by the closing date of Thursday 24 February, is available on our website. The petitioner would be welcome to share their views with us.

Impact of the waiting times backlog on people in Wales who are waiting for diagnosis or treatment

We are currently undertaking an inquiry on the impact of the waiting times backlog on people in

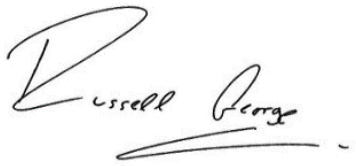
Wales. In addition to exploring issues relating to waiting times for mental and physical health diagnosis and treatment, it includes consideration of access to psychological therapies and emotional support for people who may be experiencing anxiety or distress as a result of long waiting times.

To inform our inquiry, we have held oral evidence sessions with key stakeholders across the health sector, in addition to issuing a call for written evidence. While this work is still in progress, and we have not yet reached any conclusions, one of the themes emerging is the impact that the waiting times backlog is having on people's mental health. In addition to having to wait to access mental and physical health services, people are also facing challenges in accessing support to help them manage their physical and mental health while they are waiting for diagnosis or treatment.

Further details about our inquiry, including the evidence that we have heard to date, are available on our website.

I hope that this information is of assistance to your Committee and the petitioner.

Yours sincerely



Russell George MS

Chair, Health and Social Care Committee

Croesewir gohebiaeth yn Gymraeg neu Saesneg. We welcome correspondence in Welsh or English.

Agenda Item 6

Document is Restricted

Agenda Item 7

Document is Restricted

Agenda Item 8

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

Evidence Submission for the Senedd Consultation on 'Hospital discharge and its impact on patient flow through hospitals' (Health and Social Care Committee Inquiry)

7th January 2022

Organisational Context

Betsi Cadwaladr University Health Board is responsible for improving the health of the population of North Wales and securing appropriate provision of high quality healthcare.

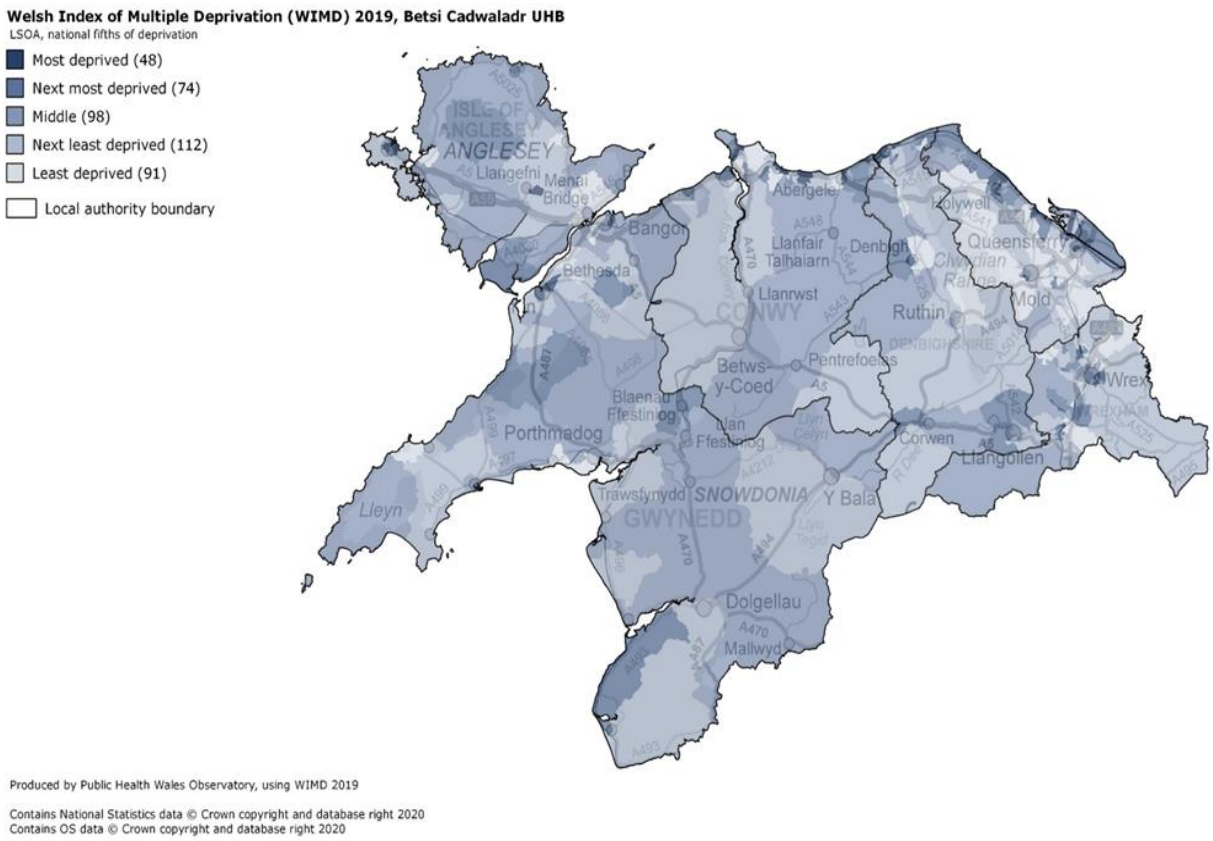
Population

The population of North Wales is approximately 700,000 and is spread across the six Local Authorities of Anglesey, Gwynedd, Conwy, Denbighshire, Flintshire and Wrexham.

Particularly relevant to this consultation is the elderly population as the majority of delayed discharges fall within this group. The table below shows the age profile of the population within the Health Board area compared to the Welsh population as a whole. This indicates a higher than average proportion of the population who are elderly (65+) and very elderly (85+).

Age group	BCUHB (%)	Wales (%)
0-15	17.6	17.8
16-64	59.0	61.2
65+	23.4	21.1
85+	3.1	2.7

BCUHB has some of the most deprived areas in Wales, with 12% of the North Wales population living in the most deprived fifth of communities in Wales. Three of the top 10 most deprived wards in Wales, as measured by the Welsh Index of Multiple Deprivation (WIMD) lie in North Wales.The graphic below shows the relative deprivation in communities in North Wales, including the most deprived -



Partnership Working

There are well established partnership working arrangements between the Health Board, Local Authorities, the Third Sector and other partners in North Wales. The Regional Partnership Board is becoming increasingly effective in promoting joint working and overseeing the development of innovative solutions to delivering integrated health and care services. The Regional Partnership Board is currently overseeing the investment of £2.2m of additional resources allocated by Welsh Government for the Health and Social Care Winter Plan. All of this resource has been allocated to Local Authorities in recognition of the vital role this sector has in positively impacting hospital flow by reducing delayed discharge.

This positive environment for joint working forms an important context for considering the issues which are outlined in this document in relation to delayed discharge from hospital. The Health Board recognises that there are specific challenges faced by Local Authority partners, particularly in relation to recruitment and retention of care staff. The Health Board continues to work collaboratively to seek to identify innovative local solutions to these challenges.

Historic Levels of Delayed Discharges

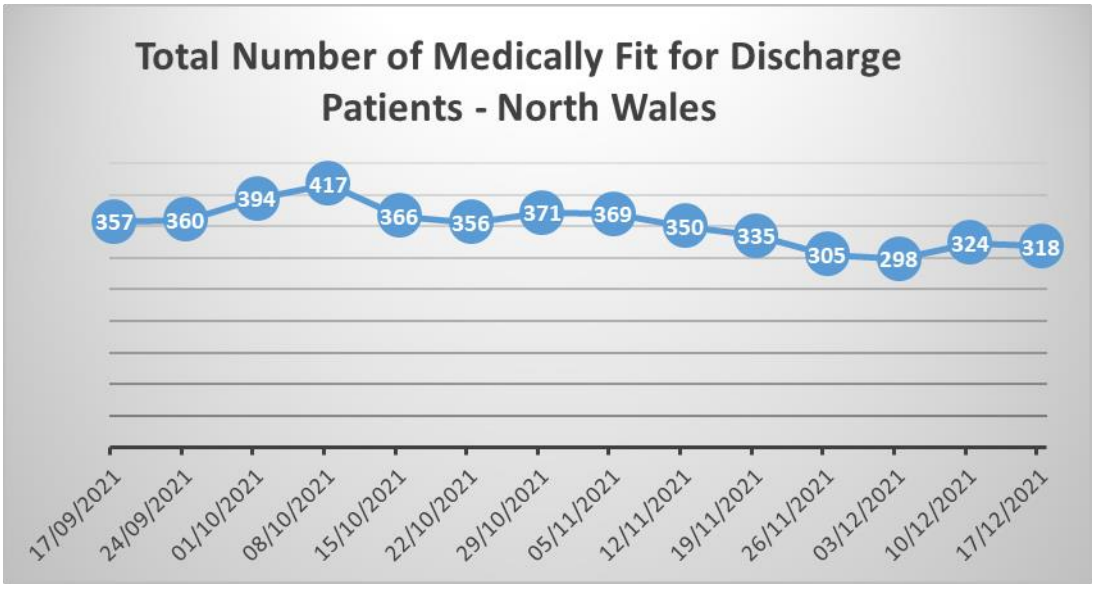
Delayed discharges have been a challenge across the Health Board for some time. Prior to the pandemic a baseline level of delays was typically in the order of 110 patients at any time, however this has now increased significantly as is set out in the responses below.

Responding to the Consultation Questions

The following section provides responses to the questions set out in the consultation.

1.The current situation with delayed transfers of care from hospital

Delayed discharges continue to present challenges in managing inpatient capacity across both acute and community hospitals. The graph below shows the level of "medically fit for discharge" patients who remain in hospital across the Health Board over the latest 14 week period –



As indicated above, these delays impact in both acute and community hospital settings, with data for 17th December showing 167 acute beds occupied (52%) and 151 community hospital beds (48%). The total number of delays of 318 equates to approximately 11 wards across the Health Board's hospitals.

There are numerous reasons for delay, covering issues within hospitals, in community services and independent care settings. The table below shows a snapshot of the reasons for delays as recorded within the Health Board –

Reasons for Delay - Snapshot 17th December 2021		
Reason	Number of Delays	%
Awaiting domicillary care	75	23.6%
Awaiting residential care home	36	11.3%
Awaiting nursing home	43	13.5%
Awaiting social care assessment	28	8.8%
Awaiting health assessment	67	21.1%
Awaiting health transfer	47	14.8%
Other	22	6.9%
Total	318	100%

As can be seen from the data above, 48% of the delays arise as a result of patients waiting to access care in the community, whether at home, in a residential home or a nursing home. This reflects the pressure upon these services and current capacity challenges. Geographically, delays are experienced across all of the Local Authority areas in North Wales despite positive working arrangements at both individual authority and regional levels. These delays are reflective of system pressures which are outlined in more detail later in this response.

2. The impact of delays on the individuals concerned

Delayed discharge can have a significant impact on patient health and wellbeing in both the short term and longer term.

Extended periods of unnecessary bed rest in hospital can lead to muscle wastage and loss of mobility with an increased risk of falls, pressure sores, loss of independence and confidence, increased risk of hospital acquired infections and worsening cognitive impairment; especially for patients with dementia. Older adults are particularly vulnerable to the detrimental effects of immobility that occur with a prolonged hospital stay. After only ten days of bed rest, older adults can lose up to 1kg of muscle mass and 16% of their strength.

Delays, along with their associated negative impacts as referred to above, can result in a requirement for an enhanced level of care at an earlier stage than would otherwise have been necessary, including earlier admission to long term care. In addition to the detrimental impacts to the individual concerned, this has a potential financial impact through increasing care costs.

Longer lengths of stay and restricted visiting deprive patients of contact with their local communities and families, which can impact negatively on mental and emotional wellbeing. This impact extends to families and carers as well as the patients themselves. Whilst actions such as the introduction of technology and video calls have assisted, it must be recognised that they cannot replace the benefit gained from face to face contact with family and friends.

In addition to the impacts upon the patients who are awaiting discharge, there are impacts experienced by patients waiting for admission in other parts of the health system. The unavailability of beds due to delayed discharges leads to an inability to admit patients with more acute needs, care being delivered in settings which are not the most appropriate for the individual's clinical need and delays in assessment and diagnosis in settings such as the Emergency Department.

Lack of bed availability also impacts upon planned care. The utilisation of surgical beds to accommodate emergency medical patients leads to the cancellation of planned procedures. From a patient perspective the ongoing delay in admission leads to further uncertainty, discomfort and potentially harm as a result of conditions deteriorating whilst patients await admission.

These impacts are described more fully in the following section.

3. Impact of delays on the system

Delayed discharges can have impacts across the whole health and care system.

Inpatient Care

Delays in discharge lead to inpatients being cared for in settings which are not the most appropriate to their need. This introduces additional risks of harm, particularly for elderly patients with dementia. The impact is felt not only in the acute setting but also in community hospitals.

The reduced availability of inpatient beds leads to an inability to care for the most acutely ill patients in a timely manner, thereby introducing additional clinical risks. The increased pressure on staff can result in a lack of sufficient time being available to spend with patients, resulting in a lower quality patient experience and less time to provide truly compassionate care. The management of a reduced bed stock and the balancing of these risks absorb a disproportionate amount of clinical and operational resource and lead to inefficiencies.

The Health Board's Unscheduled Care Improvement Programme has a number of actions focussed on inpatient care which aim to improve flow

through the hospital, thereby mitigating these negative impacts. This includes following the principles of the national SAFER patient flow programme, which is designed to enable people to return home from hospital well, safe and in a timely manner. Under this programme, the implementation of effective Board Rounds is critical in providing a focus upon the essential daily activities required to enable patients to progress their care without delay, whilst encouraging challenge and timely escalation where delays are identified. This supports the goal of timely discharge, which is a critical success factor in this work.

A second key area of work in the Unscheduled Care Improvement Programme, which impacts upon inpatient bed demand, is the provision of Same Day Emergency Care (SDEC). The Health Board is establishing SDEC units on each acute site with funding support from Welsh Government. These units aim to convert urgent and emergency bedded care to same day ambulatory care at every opportunity. They are a critical development in the management of patients with urgent care needs whose condition can be treated effectively without admission. Through these units unnecessary admissions can be avoided, bed pressures reduced and patient and staff experience enhanced.

Emergency Departments (EDs)

Inability to admit in a timely fashion as a result of pressure on inpatient beds leads to congestion in EDs, increased clinical risk and less dignified care.

Capacity in EDs has been further compromised since the start of the pandemic due to the need to manage COVID-19 risks and ensure adequate separation of patients as a key infection prevention measure. As a result the ability to assess new patients in a timely manner and manage clinical resources in a flexible manner is reduced. The implementation of same day emergency care, as described above, will reduce the pressure in ED through enabling more rapid transfer of appropriate patients from the ED. In addition the units will receive direct referrals from GPs, therapists and other clinicians, thereby avoiding the need for ED attendances. ,This will allow staff in ED to focus on a reduced number of patients, providing more timely assessment and reduced delays within the Department.

In addition to focussing on the inpatient setting, the unscheduled care programme has ongoing developments which are designed to reduce the number of presentations to ED, thereby alleviating pressure and improving patient experience. The Single Integrated Clinical Assessment and Treatment (SICAT) service, which was established in 2018, continues to expand its range of support to assist in managing demand and signposting patients to the most appropriate service. This has had a positive impact upon the ability to deliver patient care in community settings as opposed to ED. It offers

enhanced clinical support to paramedics on scene and is expanding into a broader clinical advice service for a range of community healthcare professionals such as District Nurses, to support decision making. This service is also being rolled out to Care Homes to enable access to clinical advice for their staff with the aim of avoiding unnecessary ambulance calls and conveyances to hospital. This provision is increasingly connecting with the 111 service at a national level.

Ambulance Services

Reduced capacity in EDs to assess patients in a timely manner leads to delays in handover of patients. This gives rise to inherent clinical risks for the patients involved, albeit that these are mitigated to a degree, by effective working between ED teams and Welsh Ambulance Services NHS Trust (WAST) crews. There is also a wider risk to the community which arises from a lack of WAST resources to deploy to emergency calls. This has a direct impact upon quality of care and harm arising through delay in responding to life threatening situations.

Work continues in partnership with the Welsh Ambulance Service to optimise the use of paramedic clinical expertise and to connect paramedics with other clinicians to support their decision making. Priority pathways have been identified in relation to chest pain, breathing problems and falls. The clinical assessment service referred to earlier and 111 enable more appropriate decision making and with suitable community pathways in place allow for appropriate community based care as opposed to conveyance to ED. Working with WAST, the Unscheduled Care Improvement Programme aims to increase the number of ambulance calls which can be appropriately resolved without recourse to hospital conveyance. Re-direction of patients to Minor Injury Units (MIUs), where this is appropriate, enables more rapid assessment and treatment, reduced turnaround time for ambulance vehicles and less demand on EDs. This is supported by a targeted education programme for Nurse Practitioners to deliver a consistent MIU provision across all sites.

Planned care

Increased numbers of delays in discharges lead to a reduced availability of beds to perform inpatient planned care procedures. This results in increased waiting times and associated risk of harm for patients whilst they wait for their operations, particularly in services such as cancer.

Introducing new care pathways which can optimise outpatient and day care treatment will have an impact upon the pressure on beds, however this cannot mitigate the impact of delayed discharges.

Primary Care

Where hospital services are under pressure and unable to assess and admit patients in a timely manner, pressures can escalate in primary care. This applies both within routine primary care hours and also in the out of hours and weekend period. A lack of prompt access to advice and diagnostics increases the risk to patients in the community.

The introduction of Urgent Primary Care Centres across North Wales, which can receive referrals directly from primary care or from Emergency Departments is providing much needed additional capacity across the system. Aligning this with the 111 First approach and utilising Urgent Primary Care Centres as an alternative to ED presentation will provide further benefit.

Carers

Inability to provide appropriate timely access results in the burden upon carers increasing along with the concern for the safety and wellbeing of loved ones. This can have serious effects, undermining the resilience of home care arrangements for patients.

Staff Wellbeing

The extreme pressure that staff are working under in unscheduled care services cannot be over-emphasised. The system impacts described above manifest themselves in daily challenges for staff. The ability to provide high quality, compassionate care is severely impacted. This has a direct bearing upon staff morale and wellbeing, in additional to the personal strain of intense workloads.

Many of the Health Board's planned alternative models require the recruitment of additional staff. Plans to enhance staffing levels in Emergency Departments, for example, will require the recruitment of approximately 115 additional staff. The attractiveness of these roles in a system under so much pressure is inevitably negatively impacted. Coupled with this, the ability to retain staff in existing services is proving increasingly challenging.

4. The variations in hospital discharge practices throughout Wales and cross-border, and how they are meeting the care and support needs of individuals

Historically there has been variation in approaches to addressing the challenges of delayed discharge. National initiatives such as Discharge to Recover and Assess (D2RA) are bringing more consistency although this is

not yet fully embedded and lessons learned from early implementation are being used to improve this approach.

As a result of the work to implement Discharge to Recover and Assess, there is a more consistent service provision across North Wales. The management of patients in line with standard D2RA pathways has been fully adopted, with patients supported by the Community Resource Teams in accordance with the requirements of the discharge pathway they are on. The development of capacity within community services, working in partnership with Local Authorities through Community Resource Teams is increasingly focussed upon the need to secure prompt, safe and appropriate discharge arrangements.

Alongside this, further work is ongoing to ensure that planning of hospital discharge commences as early as possible in the hospital stay. Revised local arrangements are being implemented with increasing consistency across North Wales including Board Rounds, Safety Huddles, and early discharge planning. The Health Board is progressing work in these areas under its Unscheduled Care Improvement Programme which has four key workstreams ;

- Community step up
- Hospital front door and emergency quarter
- Inpatient care
- Community services

The actions in these workstreams are aligned to support delivery of the “six goals for urgent and emergency care” set by Welsh Government.

Cross-border working with NHS England is constructive and now benefits from the adoption of the D2RA model in both countries. There are some differences in approach, such as the approach to “choice” whilst awaiting discharge which offer opportunities to learn lessons. The challenges facing the Health Board in dealing with cross-border discharges are similar to those experienced within North Wales. The lack of home care capacity and appropriate rehabilitation and recovery placements in care homes consistently present the greatest difficulties.

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

There are a number of pressure points and barriers which impact upon discharge capability. It is however important to recognise that some of the solutions lie in the more effective management of patient demand and responses to clinical need in the community, such that admission to hospital is minimised where safe, appropriate alternatives exist.

The capacity of primary care, community services, ambulance services and the third sector working collectively to offer immediate responses to need without recourse to hospital is a fundamental first step. Across the Health Board there are Step up Services provided by the Community Resource Teams to reduce hospital admissions. Referrals into these services can be through a variety of sources including Primary Care and Local Authorities. Access to these services are co-ordinated through the Single Points of Access (SPOAs) which draw together a range of resources to offer the most appropriate response to individuals' needs.

Investment in models of assessment and treatment which do not result in hospital inpatient care are also key. The Health Board has had a number of such services in place on its hospital sites and is now adopting a consistent model of robust Same Day Emergency Care services. These form a critical aspect of capacity which will lead to better patient experience, continuity of care in the community setting and release of bed capacity for acutely ill patients who clinically require this level of care. Services are expanding on each site with the aim of achieving a 12 hours a day service, 7 days a week. Furthermore each of the hospitals have CRT staff embedded in the Emergency Departments to identify patients who are appropriate to be supported to return home to recover and prevent re-admission through "right first time" discharge processes.

Systems of working within hospitals to support effective patient flow and effective discharge planning need to be operating at an optimal level across all sites. Central to this is the SAFER approach referred to in section 3 above. Staff training in the effective use of discharge tools is an essential component along with effective interfacing between hospital and community staff, including Local Authorities. Community Teams have also developed Frailty Services at the hospital sites which provide specialist multi co-morbidity support to the patients most at risk of long hospitals stays. These services are focussed on identifying and supporting patients in their first few days of admission and, wherever possible ensuring an early safe discharge home.

During the past 18 months Health Board has introduced Home First Bureaus in each of the three acute hospitals. These services provide hubs for co-ordinating and tracking patients on D2RA pathways. These hubs provide the focal point for interaction between Acute/Community and Local Authority teams on the discharge arrangements for each patient.

The capacity of the care sector, both in care homes and increasingly domiciliary care is a major concern and a focus of joint working with Local Authority partners. Local Authorities face significant challenges in recruiting care staff and this is mirrored in the independent sector. This leads to an inability to provide care safely in community settings with a direct impact upon hospitals. Joint work is ongoing to develop innovative solutions to recruitment

in the care sector under the auspices of the North Wales Regional Workforce Group.

The Health Board has worked in partnership with the Local Authorities to expand the remit of “Step down facilities” so that these services are more consistent with the principles of D2RA. The development of the new Marleyfield Care Home in Flintshire, opened in Autumn 2021, is the first example of purpose built D2RA beds within a care home in North Wales. The Marleyfield Project has been developed in partnership with Flintshire CC, includes 16 D2RA beds and provides a model for future joint projects.

The Health Board and Local Authorities are also working to repurpose existing care homes towards more jointly provided assessment services. There are challenges to care homes in this approach due to the increased turnover of patients through homes and the need to ensure safe care in the context of COVID-19. Where this care home capacity cannot be created, the Health Board has implemented interim solutions in hospital settings through the creation of “ready for home” wards, bridging the gap between acute care and community support.

6. The support, help and advice that is in place for family and unpaid carers during the process

Engagement with families and carers is a critical part of the provision of primary and community services. Community teams seek to connect patients and their families / carers with 3rd sector organisations to ensure they have access to support which will assist in maintaining and improving health and wellbeing. This support is available both pre and post discharge.

Patients and carers’ wishes are central to the discharge planning process and these are captured through the use of the “What matters to me” approach to discharge planning. This puts the needs and wishes of patients and carers at the centre of the process.

Liaison with carers commences as the discharge process is planned. This is maintained through contact from hospital staff to ensure they are engaged and informed of progress.

Specific information leaflets are available for patients and carers regarding the discharge process to assist their understanding and participation. As part of the discharge planning process information regarding 3rd sector organisations and support is shared with patients and carers

7. **What has worked in Wales, and other parts of the UK, in supporting hospital discharge and improved patient flow, and identifying the common features**

Supporting effective and timely discharge relies upon a number of key issues being addressed.

The adoption of consistent, evidence based systems of working in hospitals is critical. Examples include :

- An effective front door response within emergency departments, with models such as Same Day Emergency Care available.
- Innovative use of staff, such as the deployment of therapists and social workers in the Emergency Department
- Access to “hot clinics” to enable rapid diagnosis without recourse to Emergency Department care
- Effective inpatient flow through the consistent adoption of models such as the SAFER programme with a focus on discharge planning from the point of admission and staff appropriately trained and skilled to plan discharge effectively.

The adoption of the Home First approach whereby discharge planning focusses on the priority of returning a patient to their own home with appropriate support rather than other forms of placement has proved successful in maintaining independence, whilst also avoiding escalation of care packages and costs. Utilising the most appropriate environment for assessment leads to ongoing care support being matched to patient need and avoids “over prescription” of care support.

Consistent discharge planning and practice, based on D2RA principles with a wide range of community services available to meet the spectrum of patient needs.

Innovative solutions to capacity problems, such as re-purposing care home facilities and the creation of step up and step down facilities supported by both health and social care.

Effective collaboration with the 3rd sector to contribute to the network of support required to promote independence and wellbeing post discharge. Organisations such as Care and Repair work with the Home First Bureau to identify and provide support to patients to enable them to return home. This support can include visits to the patient’s home to ensure it is safe to return.

8. **What 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 consideration of housing needs**

   There are a number of requirements which need to be met consistently and be underpinned by robust joint working.

   A range of community based services is required which can flex to meet the needs of individuals. These must be based upon a robust single assessment across health and social care, delivered through effective joint working. Consistent and rigorous application of discharge planning and support is essential, based on D2RA principles. Effective engagement in the model from all partners, with agreed service response standards and effective processes for escalation where delays occur also aids delivery.

   A robust home care provision model which brings together health, Local Authorities and the independent sector to ensure resilience. Innovative partnerships with housing associations offer the opportunity to deliver new home care options.

   An appropriate balance of care home provision alongside home care to meet the changing needs of the population and ensure that capacity is deployed in line with the D2RA principles.

   Responsive services which can ensure that patients' homes can be appropriately adapted and equipped to enable independence to be maintained.

   New and innovative approaches to workforce planning and resourcing which can support a sustainable workforce in the care sector. This must be supported by action to secure appropriate levels of pay for social care staff. Innovative joint approaches to recruitment offer the potential for staff to recognise opportunities for career development in the combined care and health sector.

   Flexible use of resources across health and social care, including the utilisation of pooled budgets, overcoming the challenges posed by differing financial regimes eg charging for social care.

Health and Social Care Committee evidence on hospital discharge

Cwm Taf Morgannwg University Health Board – Summary briefing submission

Current CTM UHB Situation regarding delayed transfer of care

- There are currently 136 patients in our hospital inpatient beds that could be transferred into a social care setting.
    - 66 of these patients are awaiting care home placements
    - 70 are waiting for packages of care to be established.

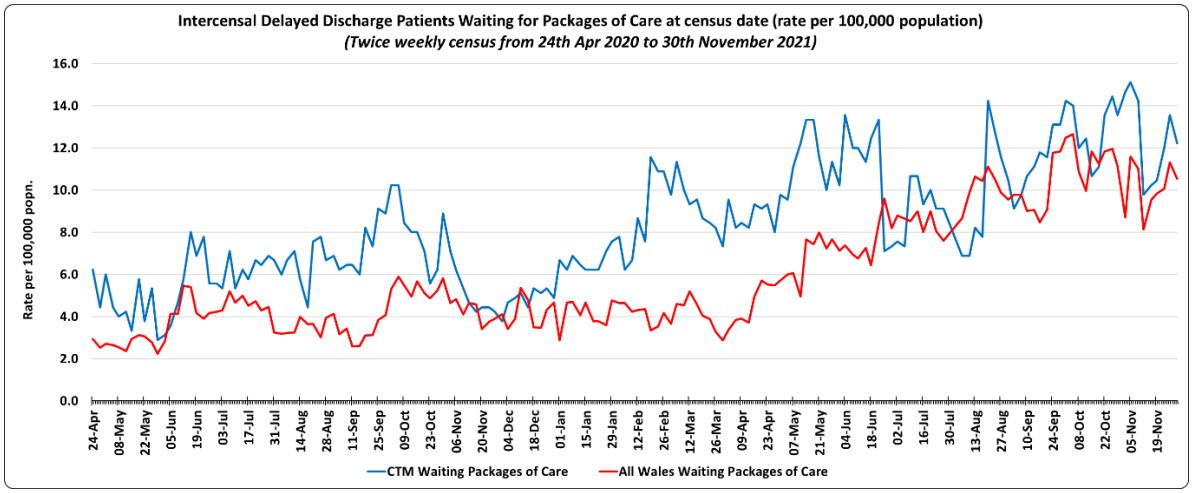
- A joint spot audit of delayed transfer of care (DTOC) patients across CTM was carried out in early December by health and social care staff. This identified 82 patients that could be appropriately placed in a residential or nursing home while waiting for packages of care or care home placements to be confirmed and organised.

Background

- Despite various schemes, incl. short term funding designed to support discharge, discharge rates have remained fairly static. One of our Local Authorities discharges between 14-25 patients per week and the staywell@home team accept 16-28 patients per week (data Oct 2021 to 9/12 2021). It has been observed that there has been an increase in the complexity of care packages required.

- Funding for community teams in health and social care has historically come via different funding routes with different timescales. An example of this is that health has been allocated non-recurrent winter funds via NHS Wales and social care have submitted winter funding requests via the Regional Partnership Board (RLB).

- Specifically, over the past 18 months the table below shows patients waiting for packages of care have steadily increase within CTM and across Wales.



Key issues

- There has been an increase in patients waiting for packages of care due to the unavailability of these packages from Local Authority providers. This information is provided by Local authorities to our "silver command" weekly operational meetings to manage covid and winter pressures.

- There has been a large increase in patients waiting for a social worker allocation due to social worker vacancies and recruitment issues.

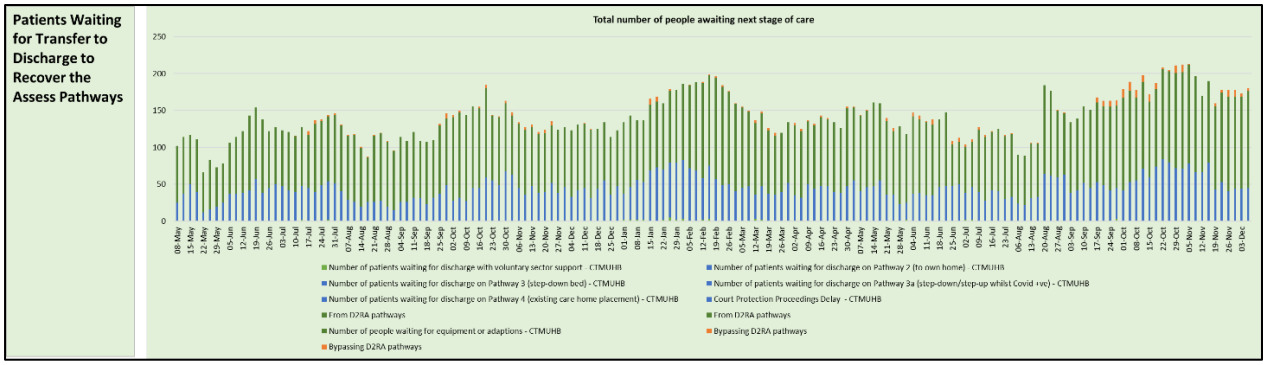
- Local Authorities are experiencing an increase in demand and case complexity from outside health referrals combined with the challenges in securing the required number of staff for the service.

- The number of patients discharged into social care settings has remained constant, however the complexity of the patients have increased and there are more requests and assessments for a higher intensity level of care required.

- The concept of a single point of access has been replaced with individual patient referrals who meet a set criteria referred to specific teams.

- The Health Board is committed to working closer with Local Authorities to ensure we are consistently aligned on the numbers of patients who are medically fit to be discharged. There are examples where understandings can differ between organisations on whether patients are truly ready to be discharged or whether they require additional needs before they can leave (e.g. awaiting prescriptions etc).

The table below identifies patients waiting to be transferred to a 'discharge to assess' pathway:



Impact

- The most readily observed impact is on the flow of patients through our acute hospital sites. This ultimately results in patients spending longer waiting in our Emergency Departments, Medical Assessment Units as well as waiting in ambulances on hospital forecourts before they are able to be admitted into the hospital. This causes knock-on delays for the Ambulance Service who then struggle to respond to urgent calls within the community, putting lives at risk.

- As the table below sets out, the Health Board's 4 hour compliance is lower in 2021 compared to 2020 along with the performance of the 15 minute ambulance handover target. This is an accepted symptom / result of lack of patient flow causes by an inability to discharge patients consistently.

Health Board Overall	01 Nov 20 - 30 Nov 20	01 Nov 21 - 30 Nov 21
4 Hour Compliance	76.89%	65.25%
Attendances	11388	14272
12 Hour Breaches	1095 (90.4%)	1463 (89.7%)

Health Board Overall	01 Nov 20 - 30 Nov 20	01 Nov 21 - 30 Nov 21
15 Minute Handover	49.86%	33.48%
1 Hour Handover	81.3% (467)	65.4% (799)
Total Handovers	2501	2312

- As an example of this, our data shows that one of our acute hospitals admits 1-2 patients per day more than it is able to consistently discharge. This means the hospital steadily fills up and eventually operates beyond its capacity requiring further short term measures to bring it back into its operating capacity. This can have a knock on impact for elective surgery if elective beds have to be utilised for unscheduled care patients.

Possible solutions

- The social care system requires support for recruitment and retention. A suggestion could be for social care staff to be employed on parity with the health 'agenda for change' terms and conditions.

- Funding should be allocated to both health and social care as an integrated system, involving key incentives to encourage a closer working relationship.

- A holistic review of all the health and social care teams at Regional Partnership Board level and a follow on recommendation of how these teams can fall under a single point of access for the benefit of patients.

- The Health Board is in the process of trying to work with Local Authorities to 'block book' care home beds to be able to increase the amount of medically-fit patients being discharged from our acute hospitals. This follows from the Swansea Bay UHB initiative in an attempt to improve patient flow.

Vivienne Harpwood, Cadeirydd / Chair

Carol Shillabeer, Y Prif Weithredwr / Chief Executive

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

CS/PH

7 January 2022

Health and Social Care Committee
Welsh Parliament
Cardiff
CF99 1SN

Dear Health & Social Care Committee

Health and Social Care Committee Inquiry: Hospital discharge and its impact on patient flow through hospitals

Thank you for inviting evidence submission in relation to the above inquiry. I am pleased to provide this written evidence to contribute to the Committee's inquiry and to provide oral evidence at the session on 27 January 2022.

Powys Teaching Health Board (PTHB) serves a population of approximately 133,000 people, across three broad natural geographies in North Powys, Mid Powys, and South Powys. It makes up a significant footprint in the rural heartland of Wales, covering a large geographical area a quarter of the landmass of Wales, with only 5% of the population of Wales. This makes it one of the most sparsely populated areas.

Powys borders England and all but one of the other health boards in Wales. As an entirely rural County with no major conurbations and no acute general hospitals, it is one of the most challenged parts of Wales in relation to access to services. People have traditionally had to travel outside the County for many services, including secondary and specialist healthcare and the cross-border links are an important part of the socio-economic life of the County.

The scale of the current situation with delayed transfers of care from hospital

The Health Board is responsible for developing and implementing pathways of care with a number of NHS and non-NHS partners. Most (non-mental health) secondary care is provided by health boards and Trusts bordering Powys. As a direct provider of services, the role of the health board is to provide community services (pre and post hospital admission) and community hospital care, usually

focused on rehabilitation and preparation for discharge/step-down. The health board therefore has a crucial role in expediating care transfers from secondary care into Powys services.
As a direct provider, the position within PTHB as at 10th January 2021 is as follows:

General community hospital beds:

There are nine community hospitals with inpatient beds and one integrated health and social care centre with intermediate care beds. As at 10th January 2022 there is a provision of 154 community hospital beds. Of these, 142 patients are occupied, given an occupancy rate of 92%.

Community hospital length of stay:

The current average length of stay for patients in PTHB community beds is 49 days. This reflects the difficulty in transferring care into the community or into a patients own home with appropriate support. Ideally a community hospital should be aiming for a 21-28 day length of stay profile, although with more intensive rehabilitation (such as Stroke care) this can be longer. Outcomes for patients can be affected by extended lengths of stay including deconditioning, leading to greater, ongoing care needs post hospital.

Discharge Fit (can also be classified as a delayed transfer of care):

There are 42 patients in 142 community hospital beds by classified as medically fit for discharge equating to 30%. This is much higher than is acceptable and is the main contributing factor to extended stays in hospital and the length of stay performance. These are categorised as: -

- No. patients ready for discharge Pathway 2 = 10 (LA=10; NHS=0)
- No. patients ready for discharge Pathway 3 =21 (LA=13; NHS=8)
- No. patients ready for discharge Pathway 4 = 0
- No. patient ready with pathway to be determined = 11

Patients returning to Powys from District General Hospitals:

As at 9th January, less than 5 patients were awaiting transfer back into Powys from a DGH.

The impact of delays in hospital discharge, both on the individual and the patient flow through hospitals and service pressures.

The impact of being delayed in hospital is significant. On an individual patient level, the deconditioning associated with extended lengths of stay where hospitalisation is not necessary, increases the level of after-care, including long term care, needed. This can, at times, make the difference between a patient being able to go home with community support services and needing to go into a care home. It is essential that optimal timing of hospital discharge can take place to enable maximum independence and recovery. The discharge to recover and

assess is a key development which seeks to reduce unnecessary harm/reduced optimisation.

Whilst strenuous efforts and significant focus goes into ensuring wherever possible that hospitals are safe environments, the challenges of infection prevention and control and of healthcare acquired impacts are clear. This has never been clearer than during the pandemic. It is also the case that patients who are delayed in hospital may experience low mood and reduced motivation, the recent protections in relation to visiting during the pandemic, despite the best efforts of staff, may also have contributed to this.

Due to the lack of domiciliary care a number of patients have had to be discharged to interim placements within care homes. Whilst this is preferred to a longer hospital stay, it nonetheless brings concerns that people will not return to their homes. Conversations to explain pressures and the lack of capacity in community resource is met with understanding from patients and families, however, the impact on individuals lives through limited care alternatives remains.

In terms of patient flow, the health board currently has approx. one third of its patients discharge ready. If these patients were to have the resource to meet their need and be discharged, all repatriation requests from other Health Boards and Trusts could be met with ample step-up community capacity available. This could further support the provision of additional step-up admissions and reduce admission to acute beds.

The variations in hospital discharge practices throughout Wales and cross-border, and how they are meeting the care and support needs of individuals.

The Health Board has Care Transfer Coordinators based in acute sites and community providers outside Powys that provide urgent and non-emergency care for Powys patients. This ensures patients are tracked and discharge planning is commenced on the day of admission. The purpose of these roles is to work with provider organisations to ensure the safe timely discharge of patients to community hospital-based services in Powys, other community services including Nursing and Residential homes or the patient's own home.

Direct discharge home is the ultimate aim, with families and support networks having a point of contact via Care Transfer Coordinators regarding the services available in planning for home. In order to achieve this, daily calls are held with all out of county providers to determine how many Powys patients are near to being 'transfer ready' and the active plans to achieve this. Prior to the Care Transfer Coordinator roles being in place (almost a decade), up to 24 patients per day could be waiting for transfer back to Powys. The only option available was largely a community-hospital transfer. As services have developed during this time a much greater proportion of people are able to go directly home and the number of patients now typically awaiting a transfer back to a Powys community hospital bed is between 2 and 8 per day, with the transfers occurring most commonly within 48 hours. Furthermore, the extension of the Home First

team to a 7 days per week service has also improved repatriation timing, reducing delays and overall length of stay reductions.

The general ethos across all acute care provider pathways is to support people to return to Powys as soon as possible. The systematisation, daily tracking and coordination through the Powys Flow Hub ensures that despite a complex system and network of DGHs that support Powys, a consistent approach is taken.

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

There are several key pressure points to discharging hospital patients:

1. Social Care capacity: This is a well published and critical issue in relation to discharge from hospital. Many patients need some community support following hospitalisation and the health board along with partners in the Powys Regional Partnership Board has been working to expand the range of support available. Whilst in many instances, successful developments have positively impacted on patients and their friends and families, the shortage of care workers is the most significant matter. The demand for and capacity available in relation to domiciliary care for example is mismatched. Significant work has taken place to try to reduce the gap, however the sustainability of the domiciliary care sector remains challenging.
2. Professional, registered social worker availability: Social care resource is depleted with recruitment challenges for qualified social workers including securing agency social workers. A trusted assessor model has assisted however this does not negate the need for the appropriate number of social workers.
3. Care home capacity: Currently, access to care home placements is extremely challenging. On a daily basis over 20% of care homes are closed to admissions and others that are open are often full. Whilst this relates particularly to the pandemic, there has been an underlying issue of care home sustainability. New models of care; developing care homes as wider community assets for example, in the medium and longer term could offer greater sustainability potential.
4. Changning discharge planning practice and broadening provision to support. Whilst significant changes in approach and thinking to discharge planning is taking place, there remain patients who are being assessed for domiciliary care needs in a hospital setting. Ideally, offering patients a range of services appropriate to their needs (step-down residential care, reablement care) could reduce both the time spent awaiting assessment and then a service provision, and the negative impacts of unnecessary hospital stay.
5. Recruitment and retainment within community therapy teams: A significant shift has been made over recent years in Powys from the provision of therapy support in hospital to this being community based. With an increase in the pathway to enable a home first approach, increased therapy support in community is required. Recruitment is challenging and despite remodelling the service, there continue to be workforce gaps. In

addition, a lack of night care provision results in decisions being made regarding the potential for a home first approach to be adopted. This is a key element that will need unlocking to maximise the numbers of people who can be supported at home.

The support, help and advice that is in place for family and unpaid carers during the process.

The Third Sector is commissioned to provide support to families and carers via Credu: Connecting Carers who work in partnership with the Local Authority and the Health Board to deliver the Information, Advice and Support Service for Carers in Powys. All carers and families have care needs assessments via Powys County Council (PCC). Literature and support are given at ward level and Powys Association of Voluntary Services Community Connectors (another service commissioned by the Regional Partnership Board) engage with wards to signpost and support families and support networks to engage and assist with planning with follow up support given on discharge.

What has worked in Wales, and other parts of the UK, in supporting hospital discharge and improved patient flow, and identifying the common features.

There are a number of key features within Powys that have worked to support more timely transfers of care, although there is more to do.

1. Care Transfer Coordination – With the complexity of the Powys pathways this service seeks to ensure every patient is supported to get back to Powys as swiftly as possible. The service is highly valued by DGH partners and has had a significant and lasting impact over the last decade.
2. Clarity of purpose of admission and admitting patients to the 'rght type of care first time' – as indicated earlier, a greater range of provision and 'alternatives' to a traditional DGH admission means that patients can be supported more appropriately with targeted care plans and Expected dates of Discharge (a target discharge date agreed by the multi-professional team and the patient).
3. 'Deep dives'/reviews into prolonged Length of Stays (LoS) with a Multi-Disciplinary Team (MDT) approach including deputy medical director, head of nursing, managers within patient flow and ward sisters has given a broader perspective to flow and problem solving of flow issues. This benefits from having a different viewpoint from a range of professionals.
4. The Right Place for Assessment: Taking lengthy assessments out of hospitals such as decision support tools has decreased length of stay, and the Complex Care Team undertaking the planning of care packages and placements which was previously held by the wards has supported flow. This has alleviated pressures on clinicians and allowed for a specific team to manage the commissioning process. Establishing a trusted assessor for reablement patients has condensed assessment times through efficiency and a simpler referral process.
5. Regularised, clear systems of managing patient flow: Systematising the flow of patients, smoothing out demand and supply of services and clear escalations assist in enabling a more 'managed' approach to flow

pathways. This means making the most of the hospital capacity available. A range of system and approaches have been used across the UK.

What 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 consideration of housing needs.

In summary, shifting services and increasing the capacity from hospital to community will make a significant difference to the quality and timeliness of the care provided. For example:

- Enhancing reablement and home therapy teams to establish a comprehensive wrap-around rehabilitation service. This would avoid the potential 'over-prescribing' of care in hospitals and allow for patients true potential to be sought in a home setting. This needs to be a rapid service which has the ability to support discharge as quickly as possible to avoid deconditioning and increased need.

- Expand the domiciliary care market including night time provision for those who have overnight care needs. This would allow for reablement teams to handover care for those who do have longer term needs and decrease the number of interim placements being used for those who domiciliary care cannot be secured.

- Increased flexibility and partnering with care homes with a particular focus on mental health care home beds with care homes embracing a trusted assessor approach. The potential to operate more as a single system is there, however building trusted assessor relationship and developments is key. Furthermore, the deep rooted workforce challenges across health and social care, need particular attention in the care home sector.

I hope this is helpful for the inquiry. Please do not hesitate to come back to me for any clarification or more information. I look forward to further participating in the Inquiry with the Committee.

Yours sincerely

Carol Shillabeer
Prif Weithredwr
Chief Executive

Health and Social Care Committee: Hospital discharge and its impact on patient flow through hospitals

Evidence from the Welsh Ambulance Services NHS Trust

1. The Welsh Ambulance Services NHS Trust welcomes the opportunity to provide evidence to the Health and Social Care Committee in its inquiry into hospital discharge and its impact on patient flow.

2. As an ambulance service, the issue of patient flow is one of critical importance given its impact on the front door of emergency units and, by extension, delays in handing over the care of patients from ambulance to hospital staff and thus the availability of ambulances to respond to emergencies in the community.

3. As a service, we recognise that the issues inherent in the flow of patients through hospitals are complex. The current pandemic has amplified and exacerbated the structural weaknesses already apparent in the health and care system prior to March 2020, which meant extended delays outside hospitals for ambulances were already a feature of the healthcare system, although not to the extent that they are currently.

4. These delays have an inevitable impact on the availability of ambulances in the community. During the first wave of the pandemic, there was considerable drop-off in what might be deemed “routine activity” which meant that ambulance availability was improved, as delays were far less prevalent.

5. As we have moved through the pandemic, and with the onset of elevated, rather than routine, levels of demand, the situation has deteriorated significantly across the health and care sector.

6. At the time of writing, the Omicron wave is moving towards its peak. The advent of Omicron has resulted in excessive strain placed upon the entire sector, with high levels of staff absences across the Welsh Ambulance Service, local health boards and in social care.

7. Couple this with high levels of demand and limited flow through hospitals, and this has seen ambulance performance levels continue to decay throughout the final weeks of 2021 and into 2022, resulting in extended waits for ambulances in the community, including for higher priority amber one calls, as well as, unfortunately, for life-threatening red calls, where performance continues to fall short of the 65% pan-Wales target.

8. The graphs in the data pack annexed to this document give an indication of the hours lost in recent months to handover delay. The stories data do not always tell are the incredibly poor experiences of patients waiting for hospital care and the frustration and moral injury to crews, many of whom regularly spend entire shifts caring for one patient outside hospitals, in the full knowledge that there are very many patients waiting in the community for whom no care is available and where risk is at its highest.

9. Similarly, the impact on performance and the concomitant impact on staff and patient experience is apparent.

10. Notwithstanding the emergence of the Omicron variant and its enhanced transmissibility, like the rest of the NHS in Wales, the Welsh Ambulance Service has extensive winter plans in place, as well as a long term plan for growth and the redefinition of the service, continuing its journey towards a service fundamentally rooted in clinical practice, rather than one providing a conveyance service.

11. The balance between managing the immediacy of the situation and planning for recovery and growth is a fine one, and one of which the Welsh Ambulance Service Board is acutely aware.

12. However, the current situation means that the WAST leadership team has expedited some longer term plans while exploring all possible means of support for the service now, including the third request for Military Aid to the Civilian Authorities (MACA), which will now run with increased number (251 frontline operatives) until the end of March 2022.

13. Much of this longer term investment and development is focused on treating as many patients at scene as possible, reducing unnecessary conveyance to hospital and thus reducing pressure on the wider health and care system through avoidable admission.

14. While there is a role for optimising advanced practice and more innovative ways of utilising clinical staff in achieving this, it is also fair to say that the success of this approach longer term will ultimately hinge on health boards, primary care and the social care sector working differently with the ambulance service, as one integrated system, to deliver care collaboratively for patients.

15. This means opening up existing or developing new pathways of care which are open to referral by ambulance service clinicians, as well as utilising clinical and social care staff differently and more appropriately to manage patients, as far and as safely as possible, in the community.

16. While acknowledging such changes often take time to effect, conversations are currently underway with a number of local authority partners to understand better how partnerships can be forged between WAST and social care to maintain more people at home.

17. Understanding the social care services that will add the most value to local people and working together, either to enable referral rights to them for ambulance staff, or developing them in partnership, possibly on a regional partnership board basis, is at the heart of these discussions.

18. Similarly, the options of digital and remote triage of calls will need to be developed much more extensively over the coming months and years to again reduce the need for the deployment of an ambulance, with the potential to refer patients to other elements of the health or social care system.

19. While work continues to properly articulate the steps and means by which this longer term ambition can be achieved, the Welsh Ambulance Service has been fortunate in receiving support from its commissioners, both to deal with the immediate pressures and to invest in the staff and models which will deliver that longer term ambition.

20. In real terms, this has included in recent months:

    (i) Employing a further 36 clinicians to work on our Clinical Support Desk, managing demand through clinical triage of lower acuity patients who can be provided with advice and guidance to avoid the deployment of an ambulance. CSD clinicians also provide support to crews on scenes with additional clinical opinion and advice, with a view to avoiding conveyance where clinically safe to do so.
    (ii) Recruitment of an additional 32 FTE emergency medical dispatchers to help answer 999 calls
    (iii) Establishing our "Winter Cell" to support coordination across the system during the season
    (iv) Implementing our "Clinical Safety Plan" which allows us to target our resources in line with demand to safeguard the most clinically vulnerable
    (v) Recruitment of additional 111 call handlers to manage elevated call volumes
    (vi) Deployment of new menu options across 111 to flow callers more appropriately
    (i) Working closely with health board partners to implement online physician triage and streaming
    (ii) Recruitment of mental health clinicians to support our clinical support desk – deployment expected early in 2022
    (iii) Corporate staff providing additional support to frontline colleagues
    (iv) Additional capacity at Morriston and the Grange University Hospital to assist with handover
    (v) St John Ambulance Cymru providing additional support
    (vi) Additional NEPTS provision to increase capacity
    (vii) Reinstating and re-profiling support from Mid and West Wales Fire and Rescue Service to include provision of a level one falls service. Training is underway and the service is expected to roll out from January
    (viii) Enhancing a range of staff wellbeing initiatives, including hospital concessions, British Red Cross staff support, pool cars for end of shift, pet therapy etc.

21. In respect of discharge, the contribution of the ambulance service's non-emergency patient transport service (NEPTS) should not be underestimated in facilitating the discharge of patients, either to their own place of residence or to "step-down" care facilities.

22. Earlier in 2021, NEPTS worked on modelling likely future demand for its discharge and transfer service over the winter months. That modelling was used to work with health boards and commissioners to identify additional funding for extra discharge and transfer resources to support additional flow in a timely manner. This capacity has been well used in recent months.

23. Whilst acknowledging the extensive work that is underway across the system, it is important that the many structural weaknesses across health and care services are addressed, rather than relying on reactive, short-term fixes to alleviate the pressures and improve the experience of patients, citizens and staff.

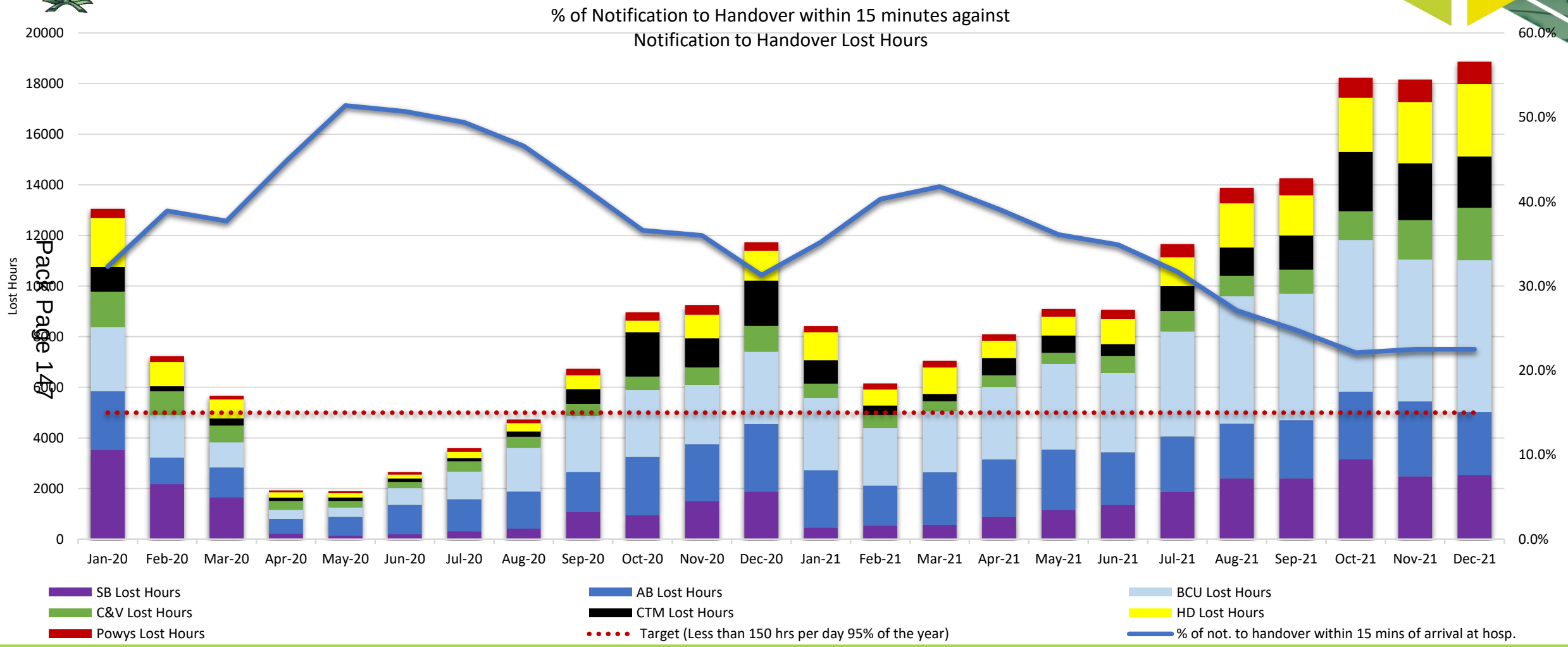
24. This must include creating an employment environment where there is parity of esteem and reward for social and healthcare staff, to facilitate improved recruitment to social care roles.

25. Similarly, while good work is underway across Regional Partnership Boards to consolidate and enhance relationships and services across the health and social care interface, there remains much to do in terms of overcoming professional and clinical barriers to provide meaningful services that genuinely address the needs of people in need.

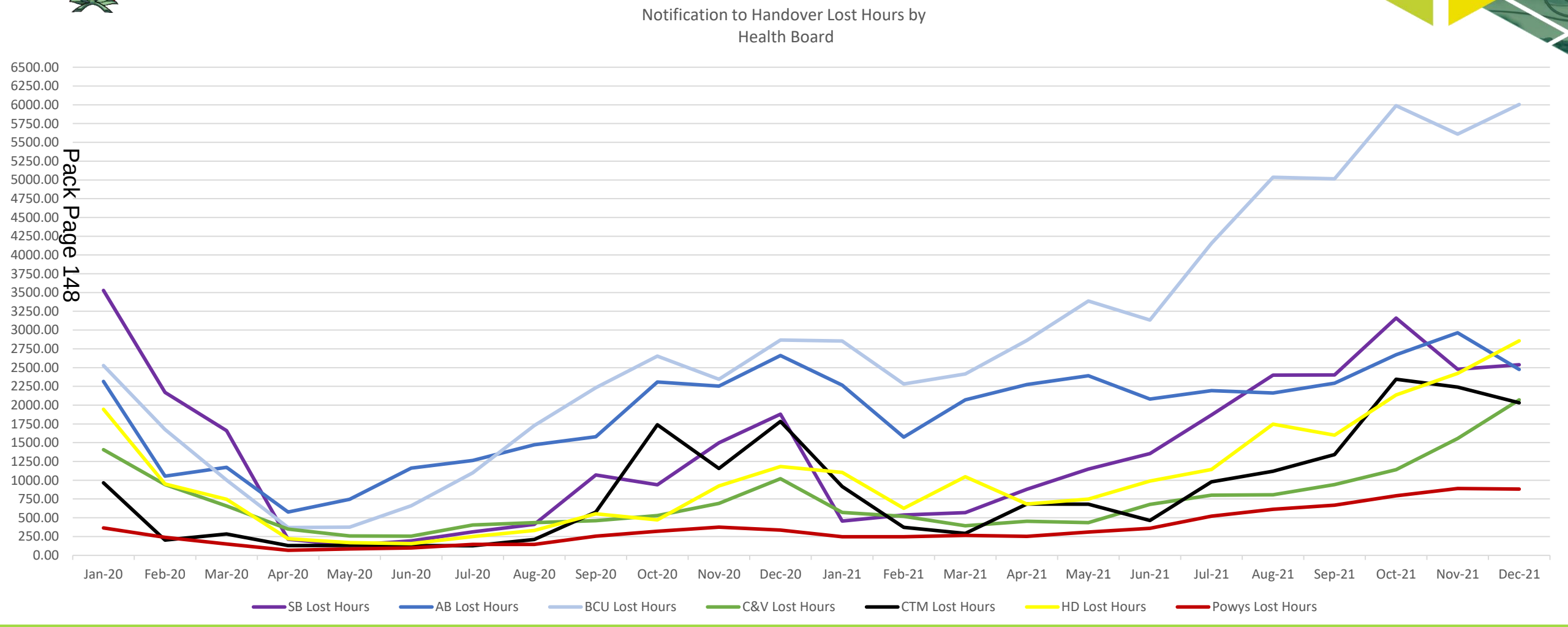
26. None of these ambitions is simple to achieve. That said, our collective experiences of the pandemic hitherto suggests that we have the platform, the collective will and the ideas to move this agenda forward at pace, with the right level of support and focus, recognising the distraction which the latest Omicron phase of the pandemic has presented.

    Ends/EVH/Jan22

Notification to Handover

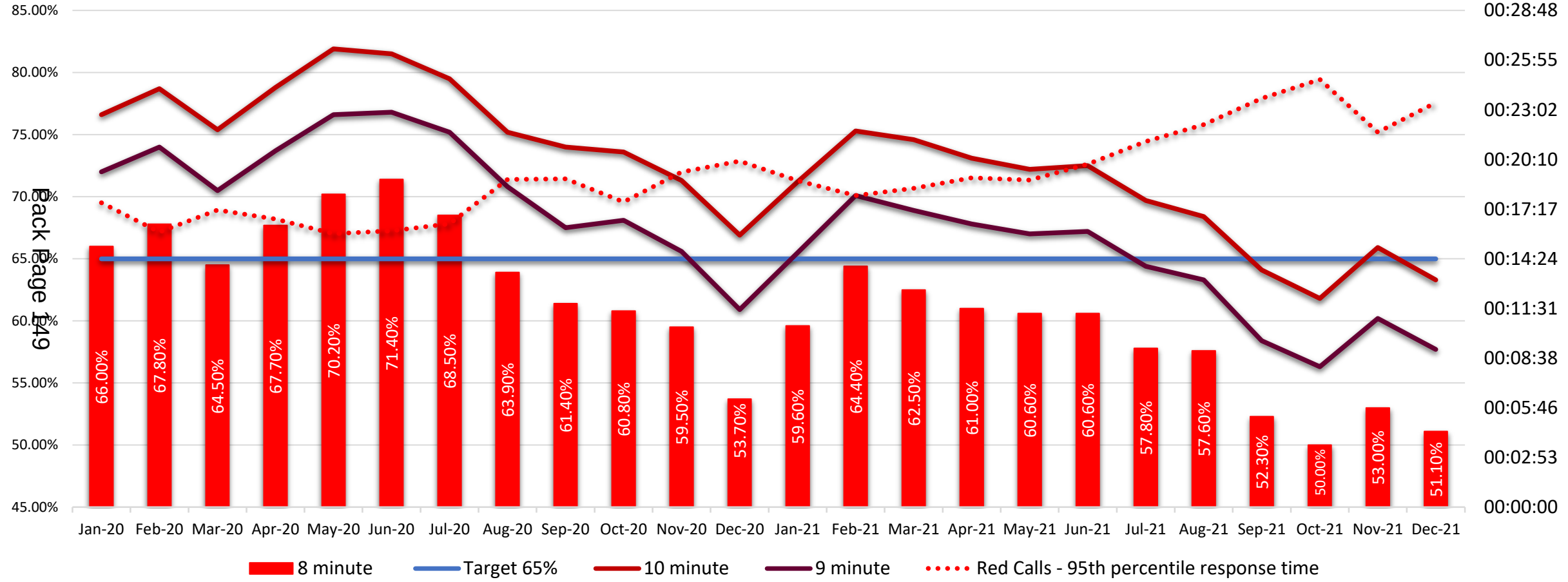


Notification to Handover by Health Board

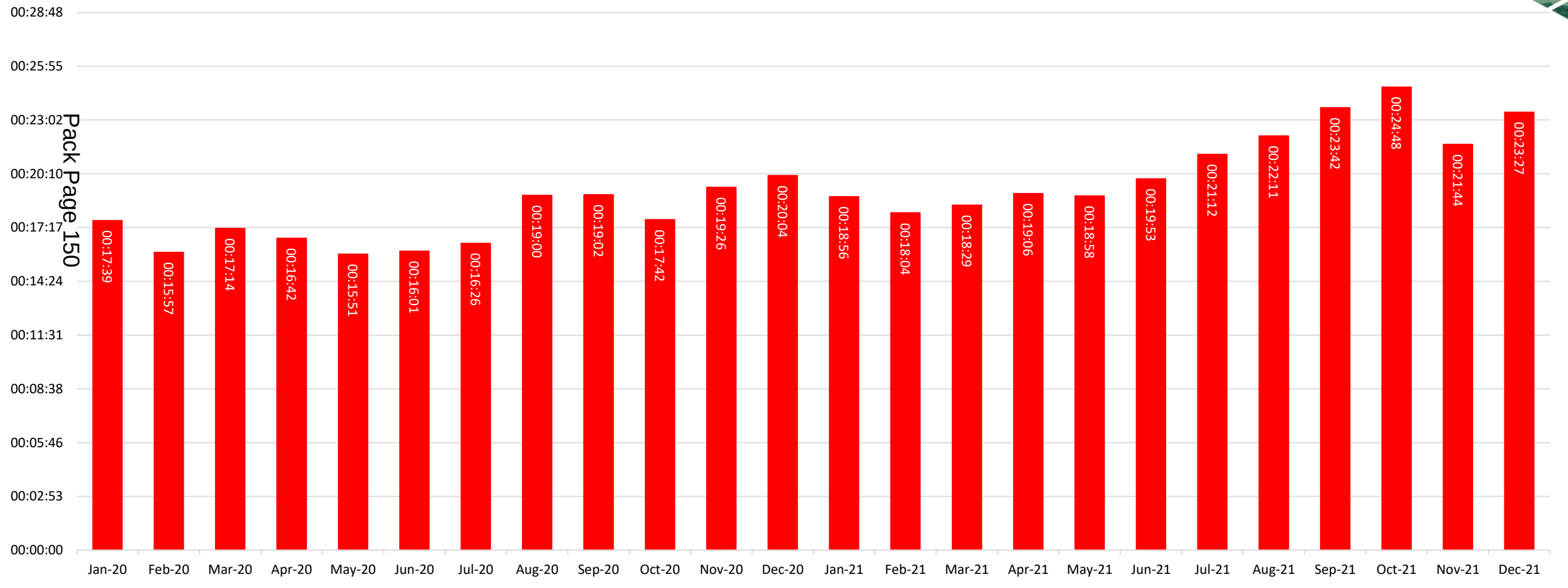


Red Performance

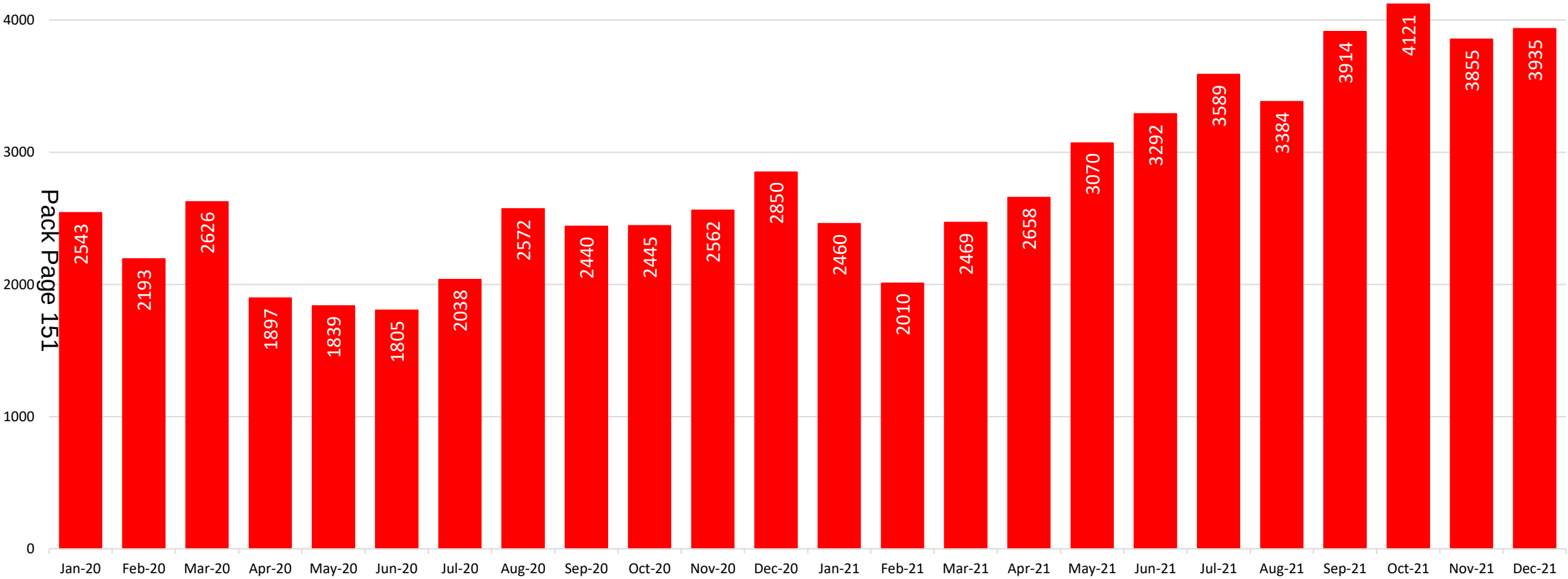
% Of Emergency Responses to Red Calls Arriving Within (up to and including) 8, 9 & 10 Minutes Aganinst Red Calls 95th Percentile



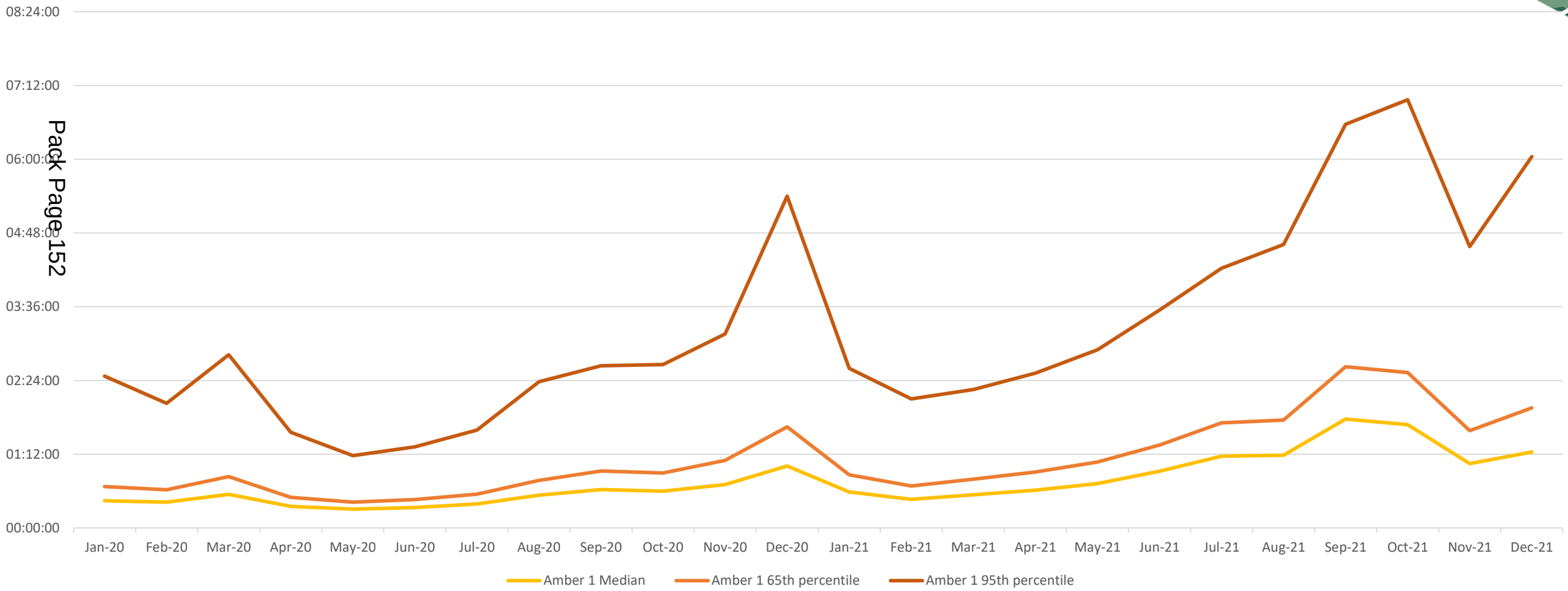
Red 95th Percentile



Red Demand Calls



Amber 1


Amber 1 Median, 65th and 95th Percentile
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06:00:00
04:48:00
03:36:00
02:24:00
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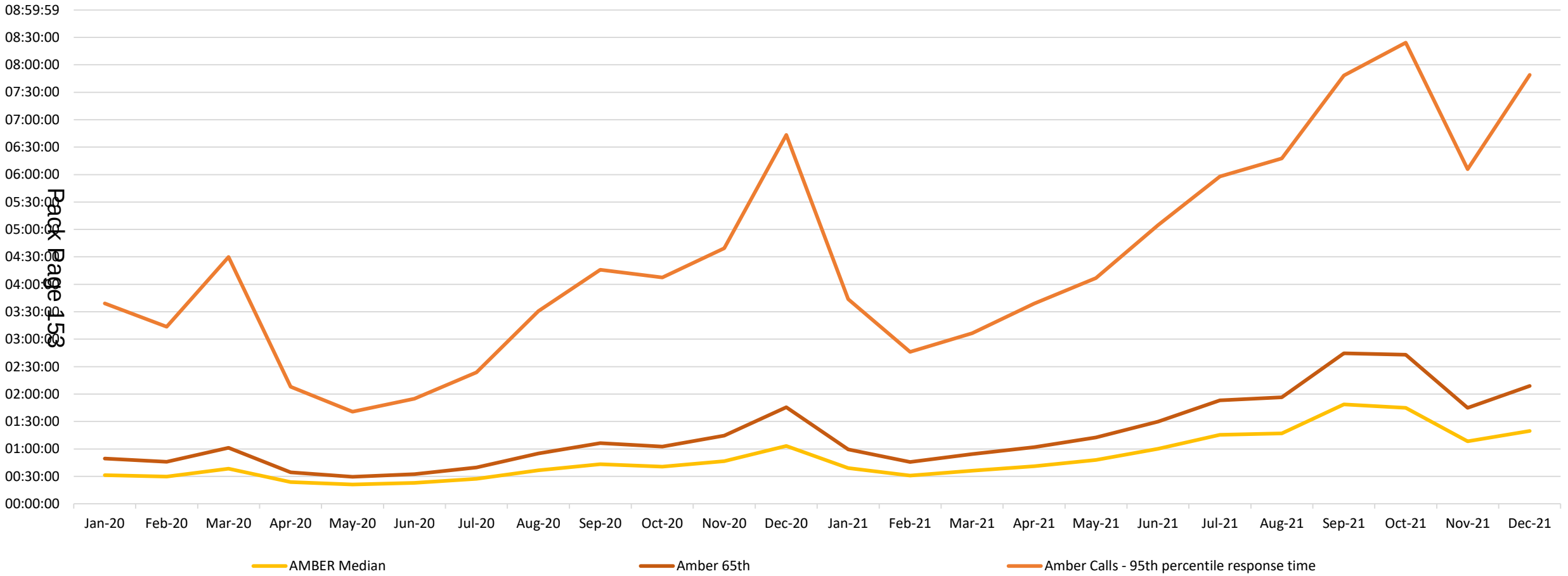
Amber 1 Median
Amber 1 65th percentile
Amber 1 95th percentile

Amber Median, 65th & 95th



Amber Demand