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.

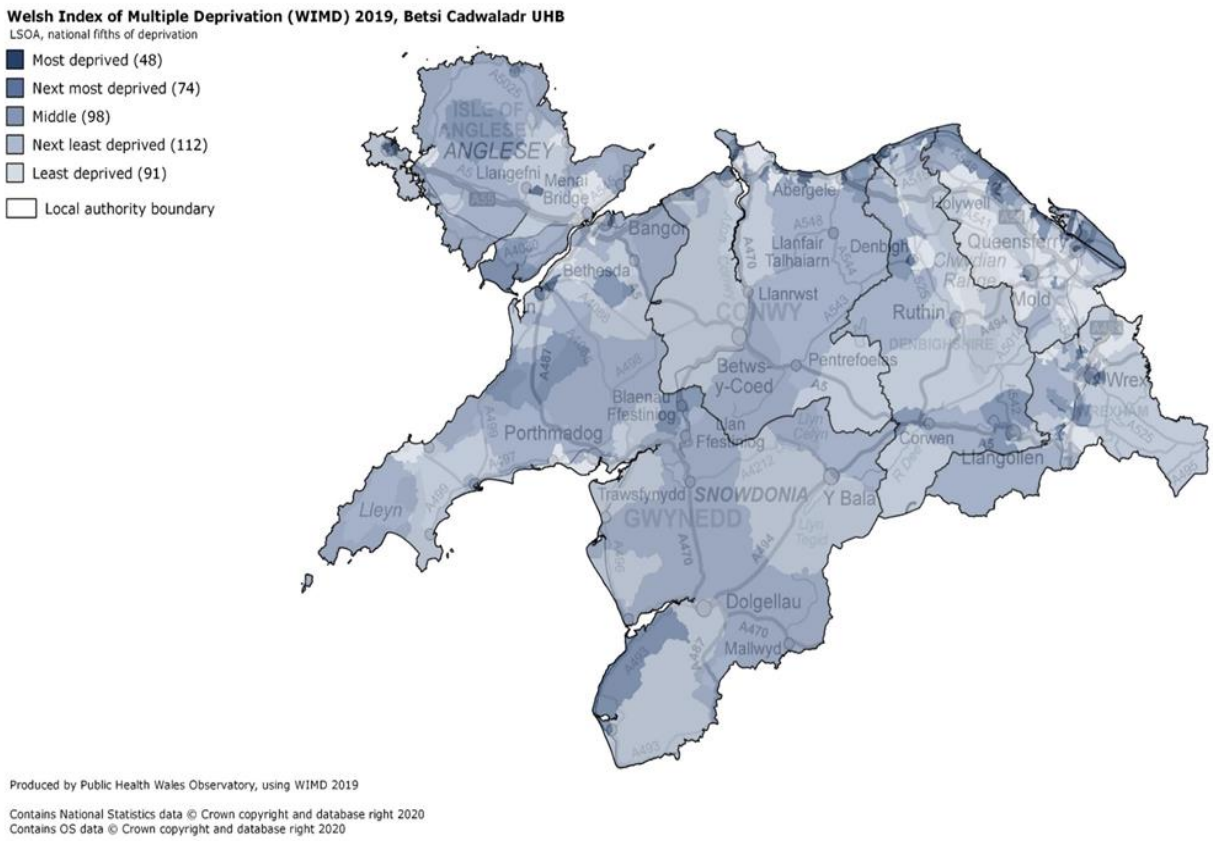
Population

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

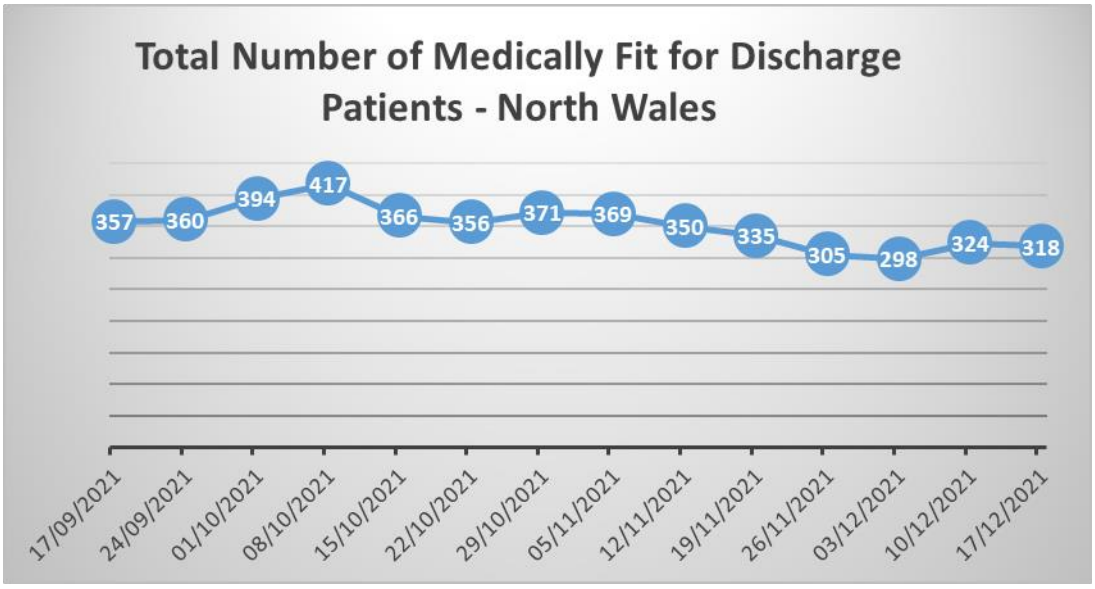
Delayed discharges have been a challenge across the Health Board for some time. Prior to the pandemic a baseline level of delays was typically in the order of 110 patients at any time, however this has now increased significantly as is set out in the responses below.

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.