Cyflwynwyd yr ymateb i ymgynghoriad y Pwyllgor Iechyd a Gofal Cymdeithasol ar rhyddhau cleifion o ysbytai ac effaith hynny ar y llif cleifion drwy ysbytai

This response was submitted to the Health and Social Care Committee consultation on Hospital discharge and its impact on patient flow through hospitals

HD 19
Ymateb gan: | Response from: Unigolyn | An Individual

The Older People's Commissioner for Wales brought our attention to this consultation, given the recent experiences of my uncle, [redacted]. With regards to the information you require along with the submission of [redacted] and my written experiences/thoughts, please be advised that:

- [redacted] and I [redacted] are both over 18 years old
- We are submitting evidence as individuals
- We request that our names are not published
- Other than our names, we do not consider the written evidence provided to be confidential
- I am sharing [redacted] experience with his permission. [redacted] and I are aware that the details may be published (without our names)

[redacted] recent experience as a patient in Cwm Taf Morgannwg Health Board

[redacted] was admitted to Prince Charles Hospital on [redacted] 2021 via his GP. [redacted] sodium levels were high; he required IV fluids to correct them. On admission it was identified that he also had phenytoin toxicity. These matters were dealt with swiftly by the medical team and [redacted] was soon deemed medically fit for discharge (within a week or so). Prior to being admitted to hospital [redacted] had received a full package of care via Social Services. In the weeks leading up to his admission [redacted] was taking longer to take his medications (as a result of his sodium derangement and phenytoin toxicity, which was affecting his alertness and cognitive functioning – which had now been resolved). Social Services therefore requested reassessment of [redacted] needs before they would reinstate his package of care to enable discharge; they wanted to undertake a CHC assessment. [redacted], his family and the nursing team requested that this reassessment be undertaken at home, as that would be a more appropriate environment for this assessment to take place, and more in line with the CHC Framework guidance. However, this request was refused by Social Services and so [redacted] was assessed on the ward. The elongated stay, as a result of the CHC assessment, meant [redacted] could also be seen by the neurologist as an inpatient for review of his meds, although this could have been carried out as an outpatient – so we saw this as a benefit to some degree.

The CHC that was conducted at PCH was considered void, due to incorrect information being used in the assessment. It was subsequently agreed that the CHC could/should indeed be carried out at home at a later date. However, because [redacted] had now been an inpatient for over 2 weeks, [redacted] usual package of care had been taken away. We were informed at this point that it is standard practice in such a circumstance (i.e. a stay of over 2 weeks) to reassess care package requirements. [redacted] care needs haven't changed for many years. [redacted] had a stroke aged 49, he is now 87. [redacted] at this point was effectively bed-blocking, and so was identified as requiring transfer to Ysbyty Cwm Cynon at the end of [redacted] 2021 to free up the acute bed for someone in medical need of it. If we had known that the CHC assessment would effectively delay [redacted] discharge due to him being in

hospital for > 2 weeks, we would have even more strongly insisted on [redacted] being assessed at home, in line with framework guidance.

In total, care requirement assessments were carried out four times. Each time an assessment was completed by the healthcare team, Social Services concluded that they did not include enough detail to adequately assess [redacted] package needs. Once the assessments were eventually considered satisfactory in terms of detail (weeks later), there were then discussions/disagreements over who should be responsible for medicines administration (Health vs Social Care). Once it was finally agreed between Health and Social Care who should be responsible, [redacted] discharge was further delayed by lack of capacity to provide a care package.

[redacted] spent over 4 months in hospital in total – he finally went home on [redacted] December 2021. During the last 3 months of his stay, visiting had been stopped as a Covid precaution at CTM HB. This compounded [redacted] sense of hopelessness and isolated him from his family. [redacted] and his family felt very distressed by the 3 and a half months wait for his care package to be reinstated. [redacted] suffers with depression, and gave up hope of ever going home. We were in contact with the Older Person's commissioner throughout – who were extremely informative and supportive. The Older Person's Commissioner and [redacted] MS Vikki Howells both wrote to the Health Board and Social Services to support [redacted] discharge home – which we were very grateful for and feel very much helped in finally getting [redacted] home.

[redacted] is absolutely relieved and grateful to be back home. However, his care package is currently spilt between two agencies. This means that [redacted] is visited 9 times a day, rather than the 5 times he requires. We hope this will be smoothed out in the near future. Due to lack of staff/staff sickness there is also no consistency in terms of who cares for [redacted]. Of course, this is a much more preferential position than being kept in hospital unnecessarily. However, it's not ideal. Excessive visits and lack of continuity of care are not an optimal means to provide support at home.

We have spoken with carers and they have identified that many colleagues are off sick or have left the profession. [redacted] carers tend to be on zero-hour contracts, and their hourly rate of pay is very low. They do not get paid for a day's work. Instead they are paid per client visit. This can result in very busy weeks some weeks, but then very little work in others, when clients go into hospital or are handed over to other agencies or pass way. In general, the carers I have spoken with do not feel valued. When [redacted] was waiting to come home, I contacted many agencies in the hope of contacting one at the 'right time' so that they may take [redacted] on their workloads. The response from all agencies was that there was lack of capacity and many stated that they were experiencing severe difficulties in recruiting new staff.

[redacted] experience was upsetting, disappointing, and somewhat shocking. No-one should be stuck in hospital for over quarter of a year waiting for a care package to be reinstated. [redacted] delay was influenced by a number of factors. We hope that by sharing his experience, this will provide a useful patient/relative insight into what we perceived some of the barriers to be.