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 30

Ymateb gan: | Response from: Mind Cymru

Mind Cymru's evidence to the Health, Social Care & Sport Committee Inquiry into hospital discharge processes

About Mind Cymru

We're Mind Cymru, the mental health charity. We work nationally and locally. Nationally, we campaign to raise awareness, promote understanding and drive change. We're also the first point of call for information and advice, providing mental health information to people in Wales over a million times every year. Locally, in communities across Wales, independent local Minds provide life-changing face-to-face support to more than 25,000 people each year.

Together, we won't give up until everyone experiencing a mental health problem gets support and respect.

This written evidence was prepared in 2020 and submitted to the then-Health Committee inquiry consultation into hospital discharge processes which was delayed following the outbreak of the coronavirus (Covid-19) pandemic. Whilst we know that the coronavirus pandemic has had a significant impact on hospital discharge processes we hope that this submission provides valuable insights and evidence relevant to this Committee inquiry.

Introduction

1. This submission focuses on and refers exclusively to hospital discharge processes and delayed transfers of care within mental health inpatient settings and the impact this has on those of us with mental health problems.

2. Effective hospital discharge processes are key to ensuring that people leaving hospital have the care and support needed to recover and stay well. Without this, people risk becoming unwell again and going back into hospital. Effective discharge processes are also key to preventing delayed transfers of care and ensuring people do not remain in hospital when they are well enough to leave. Moreover, the significant lack of mental health inpatient provision across Wales

places a greater need on preventing delayed transfers of care to free up capacity of inaptient provision. We know that NHS and local authority mental health staff and services are under huge pressures, with growing demand, constrained finances and insufficient capacity and we are committed to working with others to overcome these challenges to ensure people with mental health problems get the help and support they need.

Experiences of leaving hospital

3. In 2018, Mind Cymru surveyed 122 people who had been treated as a mental health inpatient since the commencement of the Mental Health Measure in 2012, either as a formal patient under the Mental Health Act or as a voluntary patient. Despite some examples of excellent practice, the findings highlight a number of issues negatively affecting people's experiences and suggests limited adherence to NICE guidelines (Transition between inpatient mental health settings and community or care home settings[1]) or the Code of Practice for Parts 2 and 3 of the Mental Health Measure. [2] The NICE guidelines are best-practice recommendations and the Code of Practice is statutory guidance, both are applicable to Wales and used together should ensure effective hospital discharge processes.

Co-produced discharge planning

4. NICE guidance states that discharge planning should happen at admission or as early as possible and should be done collaboratively:

> "Health and social care practitioners in the hospital and community should plan discharge with the person and their family, carers or advocate. They should ensure that it is collaborative, person centred and suitably-paced, so the person does not feel their discharge is sudden or premature."

The Code of Practice for Parts 2 & 3 of the Mental Health Measure further states:

> "It is good practice that discharge from hospital be planned as early as possible in the inpatient episode and that reviews of care and treatment plans or development of a first care and treatment plan is undertaken as part of the process"

However, only one in three people (36%) who responded to our survey said they were aware of staff reviewing or developing their care & treatment plan during their hospital stay and a quarter were unaware of any plan. Less than 1 in 20 (4%) felt very involved. More than half of people (54%) in our survey felt they were discharged too early and 14% felt they were kept in hospital too long.

[1] https://www.nice.org.uk/guidance/ng53

[2] https://senedd.wales/Laid%20Documents/GEN-LD8880%20-%20Code%20of%20Practice%20to%20Parts%202%20and%203%20of%20the%20Mental%20Health%20(Wales)%20Measure%202010-23042012-232786/gen-ld8880-e-English.pdf

Additionally, a National Audit of the Quality of Care and Treatment Plans conducted by the NHS Delivery Unit in 2018 reported that:

> "The use of CTPs and arrangements for care co-ordination during hospital stays varied across Wales. In some units, an admission is treated as a significant change of circumstances triggering an assessment and revised CTP. Others retain the community CTP as the working document but develop a nursing plan to direct treatment during the admission, with the CTP used to prepare for discharge."[3]

Sharing a written care plan

5. NICE has set quality standards including the following statement about communication on discharge:

> "People discharged from an inpatient mental health setting have their care plan sent within 24 hours to everyone identified in the plan as involved in their ongoing care".[4]

A written plan, co-owned by the person concerned and those involved in providing care, is intended to make the transition from hospital safer, smoother and more reassuring. Yet only a fifth of people who responded to our survey were given a written copy of their Care and Treatment Plan when leaving hospital. Almost three quarters (72%) did not receive a written copy and the remainder either did not know or could not recall.

Planning for different aspects of life

6. NICE guidance specifies the range of issues to be included in a care plan and pre-discharge assessment. This is further underpinned by the Mental Health Measure, which outlines eight areas of life that should be included when developing or reviewing a Care and Treatment Plan. This is a non-exhaustive list outlining the need for a holistic assessment of a person's needs; recognising that people with mental health problems may need support in any aspect of life – from accommodation, work or occupation to social, cultural and spiritual needs.

   Our survey found that that the areas of life least likely to be considered in care and treatment planning were education and training (66% said these were not well considered if at all), finance and money (67%), work and occupation (55%), personal care and physical wellbeing (53%), social, cultural and spiritual needs (53%). Despite mental health problems being the reason for admission, 50% said the same for treatment of physical and mental health problems.

Notice of discharge

[3] http://www.wales.nhs.uk/sitesplus/documents/863/5d.%2020180720%20National%20Assurance%20review%20of%20CTP%20Final%20Report.pdf

[4] https://www.nice.org.uk/guidance/qs159

7. NICE guidance says to give at least 48 hours' notice of discharge[5]; this gives people time to prepare practically and emotionally for leaving hospital, and for support to be put in place. However, two thirds of people who responded to our survey told us they received less than 48-hours' notice or no notice at all that they were due to be discharged. Almost a quarter (22%) told us they received 48 hours' notice or more.

Follow-up support

8. Issues relating to follow-up support post-discharge from inpatient care have previously been highlighted by the Health & Social Care Committee's suicide prevention inquiry. Recommendations 9,10 & 11 of '*Everybody's Business – a report on suicide prevention*' called on Welsh Government to improve follow-up support, to ensure data in relation to follow-up support was recorded by all Local Health Boards and that Welsh Government publishes this data on six-monthly basis to improve transparency and accountability.

9. We welcomed these recommendations as discharge planning and support is an area that Mind Cymru has campaigned to improve over many years. Our own research in 2017 revealed that only one of seven Local Health Boards were able to record whether people discharged from inpatient care received follow-up within five days. This is despite this being a key target for Local Health Boards within the Together for Mental Health 2016-19 Delivery Plan. The Welsh Government's response to '*Everybody's Business'*, issued in December 2018, confirmed that only 1 Local Health Board was able to record this information at that time. Respondents to our survey told us that only a third (30%) of people received a follow-up contact within 48 hours of leaving hospital. A quarter (24%) received follow-up within five days however almost a third of people (32%) received no follow-up contact at all.

10. We welcomed the Welsh Government's acceptance in full or in principle of the above recommendations. However, we note that their implementation was dependent on the delivery of the Mental Health Core Dataset (MHCDS). Mind Cymru has supported the Welsh Government in developing the MHCDS yet we remain significantly concerned at the ongoing delays in its delivery. The original Together for Mental Health Delivery Plan 2012-16 committed to ensuring the MHCDS was operational by 2015.

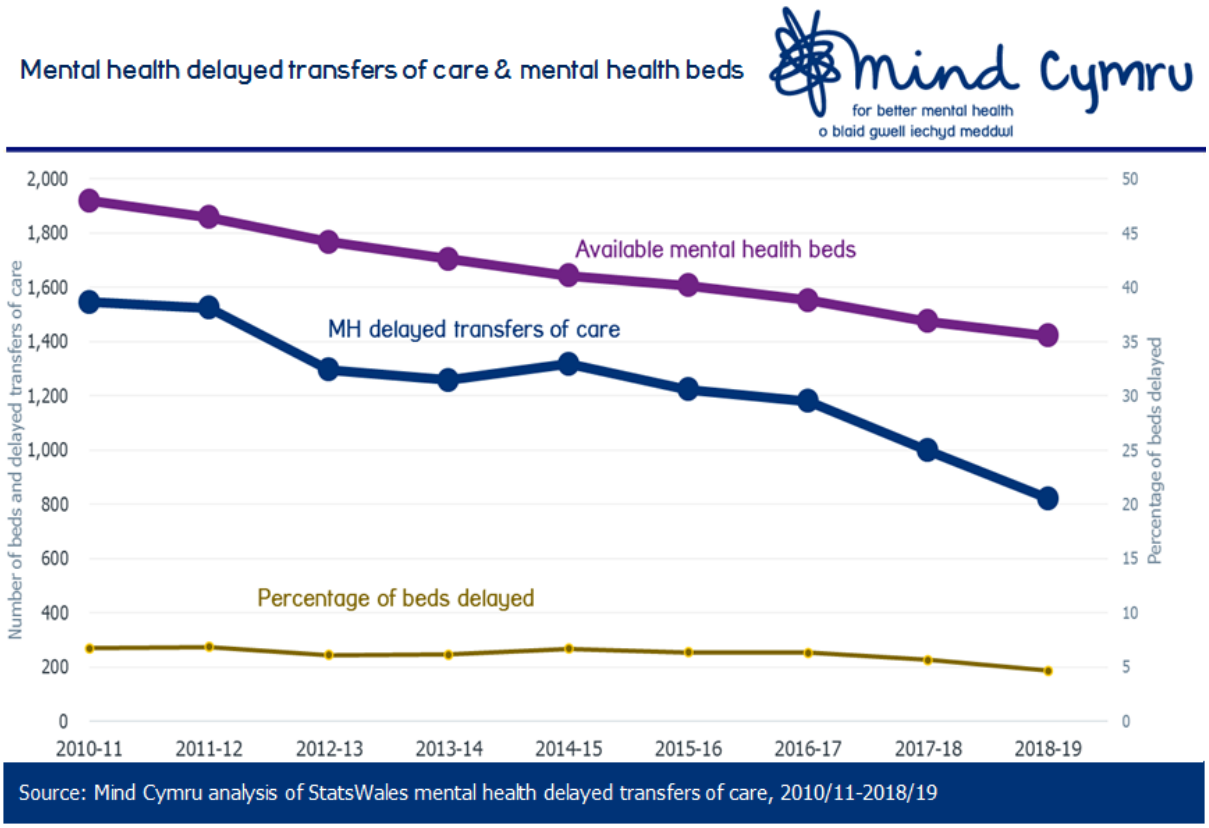
11. Moreover, in accepting Recommendation 10 of '*Everybody's Business'*, Welsh Government committed to introducing six-monthly reporting of the target for follow-up support post-discharge from inpatient care, once the MHCDS was operational. However, we note with disappointment that this commitment was not included in the Together for Mental Health Delivery Plan 2019-22. Indeed, a commitment to providing six-monthly data reports on targets within the Delivery

[5] https://www.nice.org.uk/Guidance/CG136

Plan was withdrawn following public consultation. It is unclear how or why this decision was made and we remain concerned at the Welsh Government's approach to transparency & accountability and the barriers this creates to improving service delivery and patient experience and outcomes. We recommend that the Health Committee revisit these recommendations to ensure Welsh Government delivers on its commitments.

Mental health delayed transfers of care

12. In 2018/19 there was on average 68.5 people per month subject to a delayed transfer of care within mental health settings. Whilst the number of mental health delayed transfers of care has decreased over the past ten years, the number of mental health beds has fallen significantly over the same period. As a result, the proportion of beds delayed has remained relatively static, at around 5% over the period; this is illustrated in the graph below.



Source: Mind Cymru analysis of StatsWales mental health delayed transfers of care, 2010/11-2018/19

13. The causes of delayed transfers of care are complex and vary geographically. For example, in urban areas affordable housing may be a common issue whereas in rural areas, access to social care may be more prominent; this underpins the importance of using the data both locally to address specific issues and nationally to ensure effective systems are in place to do so.

14. Mind Cymru analysis of the reasons for delays over a three year period from 2016/17-2018/19 (appendix a) shows that the largest number of delays were due to 'healthcare assessments', these accounted for 21% of delays over the period. The second most common reason for a delay was 'community care arrangements' (for example, housing issues or the need for home adaptations), these accounted for 17% of delays over the period. Both the 'selection of care at home' and 'availability of care home' are also significant causes of delays. Combined, these accounted for just over 30% of all delays during the three-year period.

Measuring mental health delayed transfers of care

15. The Welsh Government collect and regularly publish data on delayed transfers of care, including an annual statistical report that provides a narrative and analysis of changes over the long-term.[6] Delayed transfers of care within mental health settings are collected separately to other settings; this reflects the historic disproportionately higher levels recorded within mental health settings.

16. However, the data published on delayed transfers of care is from a service-perspective. Little evidence or analysis is published from a patient-perspective, for example, the impact that delayed transfers of care have on people's treatment, recovery and overall experience of care and support. It is unclear whether Local Health Boards currently seek to capture this information. A greater commitment to learning from and acting on the experiences of people using services would provide additional and ongoing opportunities to improve hospital discharge processes and prevent delayed transfers of care.

17. More broadly, whilst the way in which delayed transfers of care are currently measured can reveal much about the reasons for delays. These insights are only of value when used to inform and improve service planning both nationally and locally. Health Inspectorate Wales in their Annual Mental Health Inspection Report, published in 2018, has previously highlighted this issue:

> "Delayed discharges were also a theme on some of the wards that we visited. Health Boards had Delayed Transfers of Care monitoring processes in place but it is essential these processes are used in a proactive way to manage the provision of beds." – **Public Health Wales, 2018.[7]**

Similarly, Public Health Wales has repeatedly highlighted a lack of strategic planning to address the limited availability of services, for example, their annual inspection report published in 2019 notes a lack of provision of "low secure beds and [that] this was clearly having an impact on delayed discharges." However, despite PHW having highlighted the impact of this in annual inspection reports over several years, the issue has not yet been resolved. Such examples evidence

[6] https://gov.wales/delayed-transfers-care
[7] https://hiw.org.uk/sites/default/files/2019-06/180329mhaen.pdf

the need for a greater focus-on and commitment-to using data and insights to plan and improve services, alongside how effective scrutiny can ensure this.

18. Whilst there is a significant amount of data published on delayed transfers of care, particularly in comparison to other mental health settings, this data could be improved. For example, currently, the length of delays are recorded and published in 'delay bands' by weeks, as such, it is impossible to know the total number of days delayed.

19. Similarly, the way the data is currently published means that some delays are recorded multiple times across different months, depending on the length of delay. This means it is difficult to calculate the total number of individuals delayed in any year. We recommend that data collection and publication be amended to capture the total number of delayed days and the number of individuals who experience a delay.

Preventing delayed transfers of care

20. As outlined above, due to their complex nature and causes, preventing delayed transfers of care requires an ongoing commitment to learning from local and national insights to improve service planning and delivery.

Staffing

21. Ensuring adequate staffing levels is a key systemic means of preventing delayed transfers of care. Health Inspectorate Wales frequently highlight inadequate staffing levels as an area of concern, however, despite this, only limited progress has been made to address the issue.

> "In half of our visits there were deficits in the number of available staff across disciplines. While this was an improvement upon 2017-18 where we identified deficits in three quarters of visits, the numbers are still significant and we are regularly informed that recruiting the right discipline of staff remains a significant challenge for mental health services." – **Public Health Wales**, **2020**[8]

22. Insufficient staffing levels have multiple impacts on delayed transfers of care in mental health settings. Ensuring effective discharge processes requires thorough planning from the point of admittance and throughout the duration of a person's inpatient treatment, this can be a significant challenge for under-resourced staff.

23. Similarly, inadequate workforce planning often results in the overuse of agency and locum staff, which, in turn, can impact discharge planning and delayed transfers of care. Coordinating a person's discharge from hospital requires both a familiarity with individual patients and effective coordination with multiple stakeholders, such as, commissioners, Local Authorities and community mental

[8] https://hiw.org.uk/sites/default/files/2020-01/Mental%20Health%20Act%20Annual%20Report%2018-19%20English%20WEB%20FINAL.pdf

health teams. Understandably, it is more difficult for agency and locum staff to both develop and maintain these relationships.

> "The lack of staff in variety of disciplines was clearly having an impact on effective patient care. In one example the use of locum consultants was having a direct impact on the efficiency of patients being discharged" – **Public Health Wales, 2019**[9]

Moreover, locum and agency staff, by nature of their temporary roles, are less likely to be held to the same level of accountability and scrutiny for preventing and addressing delayed transfers of care as other staff. We recommend that Welsh Government prioritise workforce planning across disciplines to ensure sufficient staff are available in mental health settings.

24. We also note the previous Welsh Government's commitment to expand the scope of the Nurse Staffing Levels Act 2016, which it had committed to doing during the previous Senedd term.[10] To address the long-standing issues outlined above we believe the extension of this legislation to inpatient mental health wards should be taken forward with urgency.

Integration

25. As noted above, issues relating to the availability or selection of a care home account for around a third of delayed transfers of care within mental health settings. Despite this long-standing issue, there is little evidence that these insights are used to inform commissioning and service planning. Better integration of health and social care services is critical to addressing these issues.

26. The division of health, social care, and to an extent housing, services too often results in services focusing on who is responsible for providing support, rather than focusing on the support an individual needs. Moreover, separate budgetary and commissioning arrangements across health, social care and housing means that, when a person is delayed, the cost of providing support is covered by health services; this could create a perverse incentive for Local Authorities to delay assessments so as not to take on the cost of providing support. We recommend the pooling of budgets across services to ensure a resolute focus on the needs of an individual.

Learning from lengthy delays

27. People with the most complex mental health problems and support needs often face the lengthiest delays. We know that in some cases the availability of specialist care homes or supported housing provision was the main cause of delay, which further underpins the need for better integration and planning between these services. Social care and supported housing commissioners in Local Authorities must ensure that a range of provision exists to meet the complexity of need. This provision is often commissioned on a cost-basis with private and third-sector providers employing low-

[9] https://hiw.org.uk/sites/default/files/2019-07/190715MHLDHospitals%20andMHAAnnual%20Reporten_2.pdf
[10] https://gov.wales/sites/default/files/publications/2017-08/taking-wales-forward.pdf

paid support workers and providing inadequate training and support to effectively support people with complex needs.

28. Moreover, when a person is discharged from an inpatient setting to a care home or supported housing accommodation that is unable to provide effective support, this can result in a 'failed placement' with the person returning to an inpatient setting unnecessarily. Many providers are less likely to accept a person, who has previously experienced a failed placement, this, in turn, can cause further lengthy delays.

29. A greater commitment to learning from lengthy delays in particular would better enable local and national decision-makers to ensure the full range of community support is available to support people with complex needs.

Conclusion

30. The framework for delivering effective hospital discharge processes and preventing delayed transfers of care is already in place. NICE guidelines and the Mental Health Measure provide clear guidance to ensure this. However, systemic issues such as staff-shortages, insufficient training, limited capacity and siloed budgetary arrangements across health and social care create barriers that make it difficult for staff to deliver the framework. A greater commitment to learning from the experiences of people who have been treated as an inpatient or have experienced a delayed transfer of care will provide opportunities for continuous improvement. Addressing these issues requires urgency, leadership, partnership-working and adequate resourcing at both a national and local level. In turn, this will ensure that no one is kept in hospital when they are well enough to leave and those leaving hospital have the care and support needed to recover and stay well