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 33

Ymateb gan: | Response from: Bwrdd Iechyd Prifysgol Aneurin Bevan | Aneurin Bevan University Health Board

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Aneurin Bevan University Health Board (ABUHB) response to support the Health & Social Care Committee Inquiry on Hospital discharge and its impact on patient flow through hospitals

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

  Prior to the Covid pandemic, Welsh Government (WG) received robust, validated reporting from all Health Boards and Local Authorities across Wales concerning the number of patients delaying in all hospital beds. WG had removed any local agreements being applied in order to apply a consistent approach across all Wales. This validation was a snapshot in time on a monthly basis however it did allow Health Boards and Local authorities the ability to apply a thematic approach towards their delay reasons and apply changes in practices to improve areas of concern and reduce or prevent particular delays from reoccurring.

  Delayed Transfers of Care (DToC) reporting was suspended at the commencement of the Covid Pandemic and as such the joint approach to validation is not in place, with figures collected locally and owned by Health Boards.

  The scale of the current situation is quite significant with patients occupying hospital beds who have completed their in-patient episode of care but are 'stranded' in hospital. Our DToC numbers vary from circa 200 – 250 at any given time, with the present staffing issues within domiciliary care and social care having a very real impact, together with the challenges of transferring patients back to care homes (due to Covid incidents). This is translating into other key metrics such as increased Lengths of Stay (LoS), increasing numbers of patients with a hospital episode of greater than 21 days and high numbers of patients who are categorised as Level 4/5 (based on the Welsh Levels of Care) illustrating dependency.

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

  The impact of remaining in hospital when you are ready for discharge is well known and evidenced within the literature. For the patient these include exposure to hospital-related risks such as hospital-acquired infection, the creation of physical and emotional dependency and consequent patient deconditioning in hospital. The National Audit for Intermediate Care cited a delay of seven days can result in a 10% decline in muscle strength due to long periods of immobility (emphasised through the national End PJ Paralysis campaign). From a system perspective DToC means a lack of available beds for other patients (scheduled and unscheduled) and therefore impact on patient flow and increasing costs.

It would perhaps be prudent to focus on the impact of poorly planned discharge or premature discharge to illustrate the broader challenge for health and social care and indeed the patient and their family. Much of the literature & evidence refers to sub-optimal care as a direct result of poorly coordinated and premature discharge arrangements, with avoidable adverse events and in some instances post-discharge deaths. Whilst risks can be variable and complex, ineffective collaborative working and poor communication are often cited as key contributors to unsafe patient discharge. This clearly impacts on the patient and the system.

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

  There have been significant efforts to secure a consistent approach to hospital discharge from a national perspective, some of which have been driven by the Delivery Unit.

  We have policies and multiple initiatives aimed at enhancing safe, timely and effective hospital discharge but it could be seen that the policies are initiatives focus on process as opposed to the complex system within which health and care operate and the vulnerable connections between stakeholder organisations.

  From an ABUHB perspective, our geographical area is made of five Local Authorities; Blaenau-Gwent, Caerphilly, Monmouthshire, Newport and Torfaen. The Health Board also liaises with Powys Teaching Health Board for residents in South Powys as well as Hereford and Gloucester for cross-border care.

  In reality, there is system complexity with each Local Authority operating differently with different models of care and bespoke ways of working which makes hospital discharge for Health Board staff confusing, exacerbated by vulnerable connections.

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

  Safe, timely, effective hospital discharge is ever-more challenged at the present time as a direct result of the pandemic. The reasons are multi-faceted and some of which have been outlined above.

  The main challenges are bullet pointed, albeit simplistically, below and include:

  - Workforce gaps across health and social care (most notably, but not exclusively, domiciliary care);
  - The fragility of the independent sector (Care Homes);
  - Interagency communication;
  - Demand and capacity mis-match, increasing LoS and patient dependency couple with pressure to discharge which can equate to premature discharge;
  - Knowledge, skill and competency in the discharge process; and
  - Differing accountabilities between health and social care.

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

  Gwent has a number of established citizen panels which are made up of informal carers, unpaid carers and service users. The panels have been instrumental in the development of targeted documents which are easy to understand and relevant to patients, carers and family at the time of discharges.

  We have well-established discharge coordinators who support more complex discharge and operate at an inter-organisational level. They have a deeper understanding of the discharge process and help navigate the system, aligning divergent ways of working and supporting families/unpaid carers. That said, multiple national audits and independent reviews (Carers UK for example) show there is an increase in care burden which is having a detrimental impact on the health and well-being of unpaid carers.

  We believe there is an increasing reliance on families and unpaid carers, especially with the workforce gaps evident currently and this may cause unintended consequences upstream.

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

  - Hospital Discharge seen as one of multiple transitions in a patient's journey and a risk episode (not a simple transaction);
  - Discharge Coordinators;
  - The SAFER initiative;
  - D2RA;
  - A pathway approach: on admission, during admission and 48 hours pre-discharge, day of discharge safety checks and post-discharge follow-up;
  - Transitional and intermediate care models;
  - MFFD and TEPS;
  - The Trusted Assessor mode; and
  - Choice Policy.

- **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**

  A cultural shift across the way health and social care operate and interact. Within ABUHB we have very good working relationships with our Local Authority colleagues, however working together to get patients in the right place at the right time needs to be improved, with greater system thinking and joined up service provision, with more of a risk-based approach.

  Patients are admitted for a specific health care reason however health services have generally had a culture of "fixing" every part of a person's life and addressing the entirety of their social care needs; when quite often these needs were long standing or already being addressed at home prior to their healthcare 'blip'. The delay in the patients discharge through this perceived misconception that discharge home is no longer safe to continue without formal

services as opposed to 'wrap-around' services being in place has the detrimental impact of deconditioning individuals resulting in an increased dependency.

The Delivery Unit model of Discharge to Recover to Assess and what good looks like clearly evidences how reablement services should be operating on pathway 2 (and indeed on pathway 0, 1 and 4) we have listed below as a focus on the need to not lose site of excellent work already identified however the issue still remains on how will this consistently be achieved when there are inconsistencies across models within an area of five (6) Local Authorities.

DISCHARGE TO RECOVER THEN ASSESS IN A PERSON'S OWN HOME

What good looks like……

1. Any existing plans, including Anticipatory and Advance Care Plans, will be conveyed to hospital with the patient or electronically. These plans will be actively used in the discharge planning process.

2. An early 'What Matters to Me' conversation will take place as soon as possible during admission, ideally at the 'front door' of the hospital (Emergency Department/Assessment Unit). What matters to the individual will be clearly communicated and will form the basis of all multi-disciplinary discussions regarding discharge.

3. During the hospital admission, the ward team will use the information provided to minimise risks of deconditioning.

4. The principles of good discharge planning through 'Passing the Baton' guidance will be adhered to, including ongoing dialogue with the individual and their families (answering the 4 key questions to help patients return home) and the implementation of the SAFER patient flow bundle.

5. D2RA Pathway 2 will be the default pathway for any individual deemed likely to need new or additional support at home during their recovery period, and/or on a longer-term basis. Evidence to date indicates that we can expect around a quarter of older people admitted to hospital to be discharged on this pathway.

6. In addition, around 20% of older people discharged from hospital may need short-term practical support to get back on their feet. This can include for example, putting the heating on, settling back in, shopping, washing etc. and is often commissioned from third sector organisations. Individuals in this group do not need to be placed on D2RA Pathway 2, but the individual or the provider organisation should be able, as part of the contingency plan, to access it from the community if required.

7. A trusted assessor will attend MDT Board Rounds and, using the Clinical Criteria for Discharge (CCD) and Estimated Date of Discharge (EDD), will assess the minimum requirements needed to take the individual home on Discharge to recover then Assess Pathway 2.

That assessment will:

- Centre on what matters to the individual;
- Be strengths-based; and
- Encompass positive risk-taking.

8. This assessment will be used to co-produce the individual's Discharge & Recovery Plan, alongside the community team that will be providing the wrap-around support.

9. The wrap-around support will be:

   - Timely (i.e. available within 48 hours of the individual no longer requiring in-patient treatment);
   - Proportionate and focussed on recovery (there is evidence that care and support is currently often over-prescribed);
   - Time-limited; and
   - Funded via intermediate care.

10. The type of support provided can include a range of services, such as those listed below, and therefore the plan will need to be co-ordinated by the trusted assessor or other named individual, who will need up-to-date knowledge of what is available locally:

    - Community Resource Teams including Reablement teams;
    - Virtual Wards;
    - District Nurses;
    - Community-based therapies;
    - Community Pharmacy;
    - Equipment services (statutory and third sector);
    - Assistive technologies;
    - Community Mental Health teams; and
    - In-house support provided by social housing.

11. The nature of the support, including the enablement approach, should be clearly communicated to the individual and their family/unpaid carers (where appropriate).

12. Set timescales for the intervention should be avoided e.g. there is growing evidence to suggest that many people recover and require no further support after 2 or 3 weeks intervention. However, it is difficult to withdraw a service that is no longer required if, for example, an individual/their family has been provided with the expectation of 6 weeks support. It is recommended that all individuals on D2RA Pathway 2 should be reviewed by the MDT after 2 weeks, so that the input can be modified in response to changing need/recovery. This can then release scarce resource to provide timely support for more people ready to join the Pathway.

13. At the end of the period of supported recovery and assessment, the next steps for the individual will be agreed with them, their families and the relevant support services.

In regards to housing issues, Care and Repair services embrace the principles of co-production and prudent healthcare by working with patients and clinicians to develop housing solutions together and through our Healthcare standards we maintain the following principles however the issues of inconsistencies across ABUHB is evident.

Staying Healthy – their Healthy Homes Check and falls risk assessment are delivered as part of the Hospital to a Healthier Home (H2HH) service to ensure that appropriate, prudent action is taken to allow patients to return from hospital to a home that has already been adapted to meet their needs for safe independent living. Their H2HH caseworkers offer a full casework service, including signposting, referral and advice about local support and opportunities available. Their H2HH caseworkers also completes an income check to ensure patients are in receipt of the benefits, income, and financial support they may be entitled to, which can be used to maintain a safe and warm home.

Safe Care – They work with clinicians to understand a patient's clinical needs, as well as completing the Healthy Homes Check and falls risk assessment. This ensures sustainable outcomes for independent living over the long term.

Effective Care – all actions undertaken are to meet the needs of the individual. They take a whole person, whole house holistic approach. Their work is integral to wider policy goals and aims such as Discharge to Recovery to Assess, and care closer to home.

Dignified Care – Care & Repair want a Wales where all older people can live independently in warm, safe and accessible homes. Their mission and values centre on dignity and respect for the individual; an inclusive, person-centred approach; and a quality service that respects the different cultures and life experiences of their clients. Their staff are aware of responsibilities to make services accessible across all Equalities strands and they have an operational Equalities Guide, developed through a partnership with Tai Pawb.

Individual Care – aids, adaptations and home improvements are delivered on a case-by-case basis subject to individual need as determined through conversations with the patient, clinicians and Healthy Home Check. They take a whole person, whole house approach and their What Matters conversations ensure that individual desires as well as needs are taken into consideration before agreed services are acted upon.

Staff and resources – Their services assist NHS staff to make the best use of their time and resources. They are the eyes and ears of a patient's home, meaning clinicians can spend more time on wards rather than visiting homes.

There is also added-value from this additional level of perception, where community-facing NHS staff like Occupational Therapists and Physiotherapists can receive more information about the living environment post-discharge. Through bed days saved and avoided readmissions, they provide ABUHB with cost savings.

In relation to re-housing there is evidently a need to review and invest in a variety of step down and temporary accessible housing facilities; commission a housing focused hospital discharge service (align and address gaps in existing housing and social care discharge and admission prevention services) and develop clear hospital discharge pathways including increased focus on early referrals to and communication with housing support schemes.

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10th January 2022