Royal College of Occupational Therapists

Coleg Brenhinol y Therapyddion Galwedigaethol

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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.