Vivienne Harpwood, Cadeirydd / Chair

Carol Shillabeer, Y Prif Weithredwr / Chief Executive

GIG CYMRU NHS WALES
Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

CS/PH

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Health and Social Care Committee
Welsh Parliament
Cardiff
CF99 1SN

Dear Health & Social Care Committee

Health and Social Care Committee Inquiry: Hospital discharge and its impact on patient flow through hospitals

Thank you for inviting evidence submission in relation to the above inquiry. I am pleased to provide this written evidence to contribute to the Committee's inquiry and to provide oral evidence at the session on 27 January 2022.

Powys Teaching Health Board (PTHB) serves a population of approximately 133,000 people, across three broad natural geographies in North Powys, Mid Powys, and South Powys. It makes up a significant footprint in the rural heartland of Wales, covering a large geographical area a quarter of the landmass of Wales, with only 5% of the population of Wales. This makes it one of the most sparsely populated areas.

Powys borders England and all but one of the other health boards in Wales. As an entirely rural County with no major conurbations and no acute general hospitals, it is one of the most challenged parts of Wales in relation to access to services. People have traditionally had to travel outside the County for many services, including secondary and specialist healthcare and the cross-border links are an important part of the socio-economic life of the County.

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

The Health Board is responsible for developing and implementing pathways of care with a number of NHS and non-NHS partners. Most (non-mental health) secondary care is provided by health boards and Trusts bordering Powys. As a direct provider of services, the role of the health board is to provide community services (pre and post hospital admission) and community hospital care, usually

focused on rehabilitation and preparation for discharge/step-down. The health board therefore has a crucial role in expediating care transfers from secondary care into Powys services.
As a direct provider, the position within PTHB as at 10th January 2021 is as follows:

General community hospital beds:

There are nine community hospitals with inpatient beds and one integrated health and social care centre with intermediate care beds. As at 10th January 2022 there is a provision of 154 community hospital beds. Of these, 142 patients are occupied, given an occupancy rate of 92%.

Community hospital length of stay:

The current average length of stay for patients in PTHB community beds is 49 days. This reflects the difficulty in transferring care into the community or into a patients own home with appropriate support. Ideally a community hospital should be aiming for a 21-28 day length of stay profile, although with more intensive rehabilitation (such as Stroke care) this can be longer. Outcomes for patients can be affected by extended lengths of stay including deconditioning, leading to greater, ongoing care needs post hospital.

Discharge Fit (can also be classified as a delayed transfer of care):

There are 42 patients in 142 community hospital beds by classified as medically fit for discharge equating to 30%. This is much higher than is acceptable and is the main contributing factor to extended stays in hospital and the length of stay performance. These are categorised as: -

- No. patients ready for discharge Pathway 2 = 10 (LA=10; NHS=0)
- No. patients ready for discharge Pathway 3 =21 (LA=13; NHS=8)
- No. patients ready for discharge Pathway 4 = 0
- No. patient ready with pathway to be determined = 11

Patients returning to Powys from District General Hospitals:

As at 9th January, less than 5 patients were awaiting transfer back into Powys from a DGH.

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

The impact of being delayed in hospital is significant. On an individual patient level, the deconditioning associated with extended lengths of stay where hospitalisation is not necessary, increases the level of after-care, including long term care, needed. This can, at times, make the difference between a patient being able to go home with community support services and needing to go into a care home. It is essential that optimal timing of hospital discharge can take place to enable maximum independence and recovery. The discharge to recover and

assess is a key development which seeks to reduce unnecessary harm/reduced optimisation.

Whilst strenuous efforts and significant focus goes into ensuring wherever possible that hospitals are safe environments, the challenges of infection prevention and control and of healthcare acquired impacts are clear. This has never been clearer than during the pandemic. It is also the case that patients who are delayed in hospital may experience low mood and reduced motivation, the recent protections in relation to visiting during the pandemic, despite the best efforts of staff, may also have contributed to this.

Due to the lack of domiciliary care a number of patients have had to be discharged to interim placements within care homes. Whilst this is preferred to a longer hospital stay, it nonetheless brings concerns that people will not return to their homes. Conversations to explain pressures and the lack of capacity in community resource is met with understanding from patients and families, however, the impact on individuals lives through limited care alternatives remains.

In terms of patient flow, the health board currently has approx. one third of its patients discharge ready. If these patients were to have the resource to meet their need and be discharged, all repatriation requests from other Health Boards and Trusts could be met with ample step-up community capacity available. This could further support the provision of additional step-up admissions and reduce admission to acute beds.

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

The Health Board has Care Transfer Coordinators based in acute sites and community providers outside Powys that provide urgent and non-emergency care for Powys patients. This ensures patients are tracked and discharge planning is commenced on the day of admission. The purpose of these roles is to work with provider organisations to ensure the safe timely discharge of patients to community hospital-based services in Powys, other community services including Nursing and Residential homes or the patient's own home.

Direct discharge home is the ultimate aim, with families and support networks having a point of contact via Care Transfer Coordinators regarding the services available in planning for home. In order to achieve this, daily calls are held with all out of county providers to determine how many Powys patients are near to being 'transfer ready' and the active plans to achieve this. Prior to the Care Transfer Coordinator roles being in place (almost a decade), up to 24 patients per day could be waiting for transfer back to Powys. The only option available was largely a community-hospital transfer. As services have developed during this time a much greater proportion of people are able to go directly home and the number of patients now typically awaiting a transfer back to a Powys community hospital bed is between 2 and 8 per day, with the transfers occurring most commonly within 48 hours. Furthermore, the extension of the Home First

team to a 7 days per week service has also improved repatriation timing, reducing delays and overall length of stay reductions.

The general ethos across all acute care provider pathways is to support people to return to Powys as soon as possible. The systematisation, daily tracking and coordination through the Powys Flow Hub ensures that despite a complex system and network of DGHs that support Powys, a consistent approach is taken.

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

There are several key pressure points to discharging hospital patients:

1. Social Care capacity: This is a well published and critical issue in relation to discharge from hospital. Many patients need some community support following hospitalisation and the health board along with partners in the Powys Regional Partnership Board has been working to expand the range of support available. Whilst in many instances, successful developments have positively impacted on patients and their friends and families, the shortage of care workers is the most significant matter. The demand for and capacity available in relation to domiciliary care for example is mismatched. Significant work has taken place to try to reduce the gap, however the sustainability of the domiciliary care sector remains challenging.
2. Professional, registered social worker availability: Social care resource is depleted with recruitment challenges for qualified social workers including securing agency social workers. A trusted assessor model has assisted however this does not negate the need for the appropriate number of social workers.
3. Care home capacity: Currently, access to care home placements is extremely challenging. On a daily basis over 20% of care homes are closed to admissions and others that are open are often full. Whilst this relates particularly to the pandemic, there has been an underlying issue of care home sustainability. New models of care; developing care homes as wider community assets for example, in the medium and longer term could offer greater sustainability potential.
4. Changning discharge planning practice and broadening provision to support. Whilst significant changes in approach and thinking to discharge planning is taking place, there remain patients who are being assessed for domiciliary care needs in a hospital setting. Ideally, offering patients a range of services appropriate to their needs (step-down residential care, reablement care) could reduce both the time spent awaiting assessment and then a service provision, and the negative impacts of unnecessary hospital stay.
5. Recruitment and retainment within community therapy teams: A significant shift has been made over recent years in Powys from the provision of therapy support in hospital to this being community based. With an increase in the pathway to enable a home first approach, increased therapy support in community is required. Recruitment is challenging and despite remodelling the service, there continue to be workforce gaps. In

addition, a lack of night care provision results in decisions being made regarding the potential for a home first approach to be adopted. This is a key element that will need unlocking to maximise the numbers of people who can be supported at home.

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

The Third Sector is commissioned to provide support to families and carers via Credu: Connecting Carers who work in partnership with the Local Authority and the Health Board to deliver the Information, Advice and Support Service for Carers in Powys. All carers and families have care needs assessments via Powys County Council (PCC). Literature and support are given at ward level and Powys Association of Voluntary Services Community Connectors (another service commissioned by the Regional Partnership Board) engage with wards to signpost and support families and support networks to engage and assist with planning with follow up support given on discharge.

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

There are a number of key features within Powys that have worked to support more timely transfers of care, although there is more to do.

1. Care Transfer Coordination – With the complexity of the Powys pathways this service seeks to ensure every patient is supported to get back to Powys as swiftly as possible. The service is highly valued by DGH partners and has had a significant and lasting impact over the last decade.
2. Clarity of purpose of admission and admitting patients to the 'rght type of care first time' – as indicated earlier, a greater range of provision and 'alternatives' to a traditional DGH admission means that patients can be supported more appropriately with targeted care plans and Expected dates of Discharge (a target discharge date agreed by the multi-professional team and the patient).
3. 'Deep dives'/reviews into prolonged Length of Stays (LoS) with a Multi-Disciplinary Team (MDT) approach including deputy medical director, head of nursing, managers within patient flow and ward sisters has given a broader perspective to flow and problem solving of flow issues. This benefits from having a different viewpoint from a range of professionals.
4. The Right Place for Assessment: Taking lengthy assessments out of hospitals such as decision support tools has decreased length of stay, and the Complex Care Team undertaking the planning of care packages and placements which was previously held by the wards has supported flow. This has alleviated pressures on clinicians and allowed for a specific team to manage the commissioning process. Establishing a trusted assessor for reablement patients has condensed assessment times through efficiency and a simpler referral process.
5. Regularised, clear systems of managing patient flow: Systematising the flow of patients, smoothing out demand and supply of services and clear escalations assist in enabling a more 'managed' approach to flow

pathways. This means making the most of the hospital capacity available. A range of system and approaches have been used across the UK.

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.

In summary, shifting services and increasing the capacity from hospital to community will make a significant difference to the quality and timeliness of the care provided. For example:

- Enhancing reablement and home therapy teams to establish a comprehensive wrap-around rehabilitation service. This would avoid the potential 'over-prescribing' of care in hospitals and allow for patients true potential to be sought in a home setting. This needs to be a rapid service which has the ability to support discharge as quickly as possible to avoid deconditioning and increased need.

- Expand the domiciliary care market including night time provision for those who have overnight care needs. This would allow for reablement teams to handover care for those who do have longer term needs and decrease the number of interim placements being used for those who domiciliary care cannot be secured.

- Increased flexibility and partnering with care homes with a particular focus on mental health care home beds with care homes embracing a trusted assessor approach. The potential to operate more as a single system is there, however building trusted assessor relationship and developments is key. Furthermore, the deep rooted workforce challenges across health and social care, need particular attention in the care home sector.

I hope this is helpful for the inquiry. Please do not hesitate to come back to me for any clarification or more information. I look forward to further participating in the Inquiry with the Committee.

Yours sincerely

Carol Shillabeer
Prif Weithredwr
Chief Executive