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Care & Repair Cymru

Hospital Discharge and its impact on patient flow through hospitals

Written evidence submitted by Care & Repair Cymru: January 2022

Introduction to Care & Repair

1. Care & Repair Cymru is Wales' Older People's Housing Champion. Our aim is to ensure that all older people in Wales can live independently in safe, warm, accessible homes. We are the national body for Care & Repair in Wales, representing 13 independent Care & Repair Agencies (CRAs) operating in every county offering a wide range of home improvement services, tailored to client's needs and local circumstances. In 2020/21 we supported nearly 43,913 older people across Wales, 32% of whom lived alone. We carried out 36,371 adaptations in homes to help prevent trips and falls and reduce pressures on the NHS – more than double of 2019/20 output – whilst delivering £14.5 million's worth of repair and improvement work to improve the health, safety, and warmth in people's homes[1].

2. Our innovative *Hospital to a Healthier Home* (H2HH) service is cross-tenure and ensures that older people are discharged from hospital into a home fit for their needs. The H2HH service complements the clinical service offered by the NHS to make patients medically fit by providing a "property doctor" service, focusing on making patients' homes safe, warm, and accessible.

   Key to our Hospital to a Healthier Home service are:
   a) quicker safe discharges of care
   b) improved patient flow
   c) reduced re-admission rates

   Our service has expanded across Wales, now working out of seventeen principal hospitals in addition to receiving referrals from community hospitals. The service employs thirteen specialist *Hospital to a Healthier Home* caseworkers who are integrated into hospital discharge teams.

   We are committed to developing sustainable services which provide support to vulnerable, older people that helps them live independently, with dignity, and supports their health and wellbeing through improved housing conditions.

[1] For more information, please see Care & Repair Cymru's 2020/21 Annual Report. Available at: https://www.careandrepair.org.uk/files/6916/3215/1992/Annual_Report_2020-21.pdf

Care & Repair Cymru

Response

The scale of the current situation with delayed transfers of care from hospital and the impact of delayed hospital discharge, both on the individual and the patient flow through hospitals and service pressures.

In September 2021, there were 1,400 patients in Welsh hospitals who were "clinically optimised and ready for discharge, but the support they need[ed] to leave hospital [was] not available. This has the equivalent impact on bed capacity to shutting down the University Hospital of Wales in Cardiff"[2].

Our Hospital to a Healthier Home service has worked throughout the pandemic to support the Welsh NHS. This year we have seen unprecedented demand for our services:

- In the first six months of financial year 2020/21, the service received 1,961 referrals. In the first six months of this year, the service received 2,619, an increase of 34%. This shows the increased need for our service to help improve patient flow in hospitals. There are an increasing number of older patients in Welsh hospitals who are medically fit for discharge but cannot go home without a Care & Repair intervention due to the unsuitable or unsafe condition of their home.
- The number of home improvements using the same comparable time frame has increased during 2021/22 by 15%, but the value of these works is up by 117%. The huge increase in value of works is not just because of inflation and increase costs of labour and materials, which has a significant effect, but also because older people are requiring increasingly more complex adaptations. Wider repair, home safety and social welfare issues also need to be addressed, in order for them to be discharged safely from hospital and remain independent in their homes with lower risk of readmission.

The figures validate what our H2HH caseworkers tell us they are experiencing on the ground. When surveyed, our caseworkers said that Occupational Therapists are seeing sicker patients than they were before the pandemic: problems accessing services or reluctance to contact GPs during the pandemic has meant that patients have not sought healthcare until their conditions worsen to a more critical stage prior to admission. In the same way an older person can decondition over time, so does the condition of their home in terms of its viability for independent living. One caseworker noted that they have seen many patients throughout the course of the pandemic that had clearly suffered strokes but were too scared to contact the GP or emergency care in case they contracted Covid. The caseworker's concern is that if this is the case for acute conditions like strokes, then it is likely that many other chronic and longer-term conditions have

[2] https://www.nhsconfed.org/articles/painting-picture-update-pressures-facing-nhs-wales

also gone unreported, which in turn has led to more patients remaining in hospital for longer periods, creating pressure on the healthcare system.

H2HH caseworkers and hospital staff agree that there is not one particular issue, but a combination of several interlinked issues from all aspects of patient care – including the above pressures, insufficient bedspace, and insufficient social and community care opportunities – resulting in significant delays to patient discharge or transfer. This also means that there are a lot of moving parts when it comes to successfully assessing patients for discharge, and a golden window of opportunity to do so quickly and comprehensively whilst the patient remains medically fit. To be successful, innovative policies such as *Discharge to Recover and Assess* must have the proper infrastructure to ensure that patients are discharged into environments conducive to recovery. The dangers of not taking full account of the suitability of properties where patients will be discharged patients include higher risks of readmissions, and insufficient opportunity to return to confident independence, potentially resulting in loss of resilience completely.

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

We can offer comment on this from the perspective of our H2HH service. Operationally, we note that the level of integration and inclusion of our H2HH caseworkers varies across both regions and individual hospitals. For example, best practice amongst our caseworkers comes from those who are fully involved in ward rounds, discharge planning meetings and are provided a desk within the hospital amongst other inclusions which make for better partnership working that can really target earlier intervention. Where integration of H2HH is best, it is a clearly identifiable go-to service.

In some hospitals, the caseworker may not be afforded a desk in the hospital and receives most referrals remotely. Previously, we would have said that this was down to the history of the service in some areas, for example Bridgend where the service was initially piloted on a short-term visiting basis, but as relationships grew has become well integrated into the hospital. However, our service has recently expanded in ABUHB to include Ysbyty Ystrad Fawr in April 2021 and has been fully integrated. This indicates that some of the variations also come from strategic level engagement within the hospital to facilitate proper partnership working.

One caseworker noted that inequalities in funding and social provision across Wales are rife. For example, Powys does not have a General District Hospital, the lack of which makes the whole discharge process extremely difficult and contributes to problems with safe, timely discharges.

We are currently trying to secure long term, sustainable Local Health Board funding of our Hospital to a Healthier Home service. Despite the fantastic outcomes of this service and on the ground support from NHS Staff, engagement from senior level health board staff has varied across Wales. Without engagement and funding commitment from LHBs across Wales, the

service will cease to exist in some areas from April 2022. Variation will result in a postcode lottery and mean that potentially thousands of older people will experience delayed transfers of care across Wales, as well as remain in the growing pool of older patients that live under the threat of cyclical readmission.

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

From our experience, we agree with the findings in Audit Wales' report *What's the Hold up? Discharging patients in Wales.* Discharge Planning. The discharge process relies on a number of alignments leading to overcomplexity in the system. A shortage of home carers, care home beds, and "limited capacity across community reablement services are major factors in causing delays"[3]. This lack of availability of care home space was also noted by our H2HH caseworkers.

One *Hospital to a Healthier Home* caseworker, who took on the role during the pandemic and has exclusively joined discharge meetings remotely, noted that there is consistent concern between caseworkers and colleagues about the lack of community support available to enable discharge.

However, we also would like to highlight an additional point regarding the condition of housing that can mean agreed packages of care are unable to be fulfilled due to delayed transfers of care, or in some cases because of health and safety of homes in such poor condition they are deemed unsafe for care staff to enter.

Those leaving hospital with care needs also need a home fit to be cared in. Only undertaking discharge assessments around limited criteria when a patient is declared medically fit for discharge often leads to delays in transfers of care or poorly organised discharge arrangements. Without *Hospital to a Healthier Home*, which completes a full Healthy Homes Check to ensure that homes are safe, warm and accessible, hospital staff can underestimate the time needed to effectively plan discharge and ensure patients are able to effectively resume independent living whilst enjoying an environment conducive to recuperation. One Occupational Therapist we interviewed from Prince Philip Hospital in Hywel Dda noted where Care & Repair are invaluable in the discharge planning process:

> "The work that the Healthy Homes Check has done has given us more time and just more creative and flexible working.
>
> She [the H2HH caseworker] is going out anyway, and that has saved an Occupational Therapist going out, it has saved the travelling, the clinical time off the wards, and we either get the measurements of the information we need straight away, or we can link up virtually

[3] https://www.audit.wales/sites/default/files/discharge-planning-leaflet-2019-english_5.pdf (p.4).

with her when she's there… Rather than us learn late in the day that the home isn't great, and now that's delaying discharge"

– Occupational Therapist, Prince Philip Hospital, Hywel Dda

These issues are likely compounded by Covid-19, and now another winter with restrictions, meaning that housing conditions have gone unchecked and unresolved. Ward staff may also be unaware of the full breadth of community and social care packages available to patients awaiting discharge[4]. Again, this is where H2HH Caseworkers play an invaluable role and ensure that the right service is made available to the patient upon discharge.

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

Often H2HH caseworkers take on this family liaison role to allow for NHS staff to spend more clinical time on wards. One H2HH caseworker noted that one of her clients was discharged, with little warning, to their daughter's home, where she was not ready to take on his care needs and was missing experience and basic furnishings, including a bed for him. Our H2HH caseworkers offer long term support for housing needs, long after the initial essential works to enable safe discharge have been completed.

The same caseworker noted that, due to unexpected discharge and stretched packages of care in the community, many families have no choice but to provide care they would ordinarily not be able to, due to lack of experience, or be comfortable with, including peg feeding and continence care. The fundamental role that informal and unpaid care provides for the hospital discharge process is clearly under-supported.

Audit Wales also note that the support and information available to patients and their families or carers was limited when it came to the discharge process as a whole, and the services on offer to avoid readmission or long-term residential care – our H2HH often must provide this information to families[5].

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

We believe our service works in Wales. In 2020/21, we saved the Welsh NHS 20,516 bed days, saving the Welsh NHS over £5.1 million.[6] Already in the first six months of 2021/22 we have saved

[4] https://www.audit.wales/sites/default/files/discharge-planning-leaflet-2019-english_5.pdf (p. 12)

[5] https://www.audit.wales/sites/default/files/discharge-planning-leaflet-2019-english_5.pdf (p. 13)

[6] Bed day figure based on prudent estimates using NICE guidance. Savings cost calculated using NICE costing guidance, uplifted for inflation, minus total H2HH service cost in 2020/21.

the Welsh NHS 13,764 bed days, helping improve patient flow and ultimately saving the local health board money. Please see appendix 1 for a full break down of our service outcomes for April 2020 - March 2021, and appendix 2 for the services' outcomes between April and September 2021, which demonstrate the continued improved performance of the service.

Quick referrals into our H2HH service leading to early intervention, result in the better outcomes for quicker patient discharge. For this to happen, third sector partners should be fully integrated into the hospital setting – areas where H2HH has been longer established and more fully embraced by health partners via co-location and integration into discharge planning teams are the areas where we receive higher volumes of referrals and are able to assist more patients and staff with safe hospital discharge.

Often, examples of best practice, such as *Hospital to a Healthier Home* are vulnerable due to short term funding and just as they start to become embedded, more efficient, and well used, suddenly cease to operate. Annualised short-term funding brings insecurity in terms of retaining trained, skilled, experienced staff (as they inevitably look for alternative employment towards the end of each annual funding round), restricts the ability of H2HH Caseworkers to become part of MDTs and lessons the ability to embed and improve the service strategically.

At the moment, Hospital to a Healthier Home will cease to exist in April in some parts of Wales due to funding ending, as is the case with many third sector services that support the health sector. The ideal scenario is embedding proven services such as H2HH long term though LHB funding. However, if this is not achieved, we will seek alternative funding sources, possibly transformation funding or ICF through Regional Partnership Boards. However, this simply prolongs the challenges associated with short term annualised funding year on year.

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.

Care & Repair's Hospital to a Healthier Home service has been funded for three years by direct Welsh Government funding and supported by the National Program for Unscheduled Care. Strong outputs and outcomes in terms of ensuring that patients homes are fit to return to, safe, warm and suitably adapted have been achieved, backed by quantitative and qualitative evaluation is being promoted across Wales for its clear contribution to the strategic Discharge to Recover and Assess model.

Care & Repair Cymru and Care & Repair Agencies have facilitated, embedded and serviced active partnerships with NHS acute secondary care services to link housing within the 'whole system' approach to addressing unscheduled care pressures. We have developed NHS protocols that place housing within pathways that support rehabilitation, re-ablement and improved discharge planning. Care & Repair has also been at the forefront of developing approaches and

funding streams that help support quicker safe discharges home, such as the unique to Wales, national and embedded Rapid Response Adaptations programme (with £3 million available in 2022/23 to support discharges through H2HH).

H2HH currently offers:

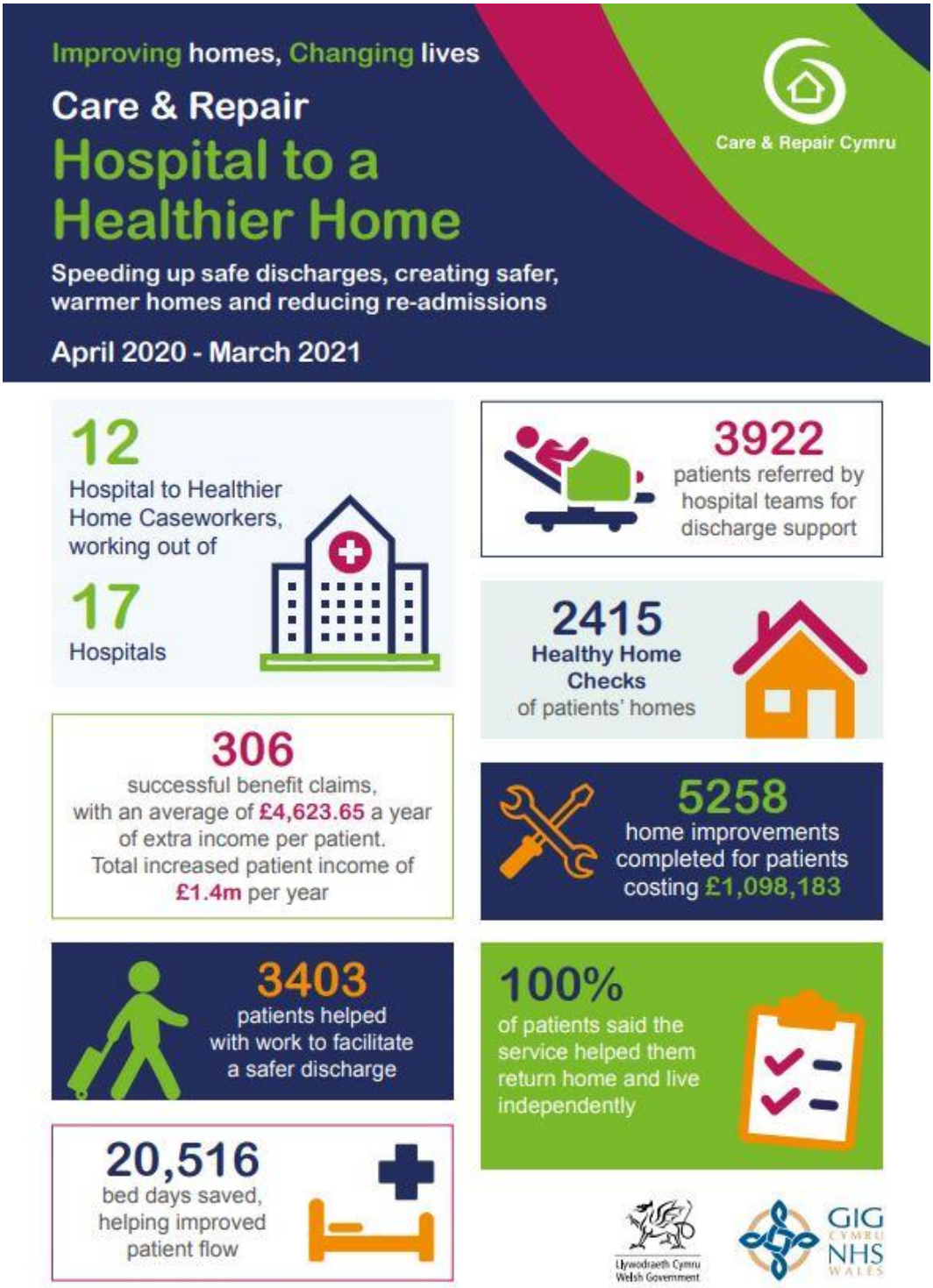
- A Healthy Home Assessment (undertaken from a standard assessment framework).
- Links to Care & Repair professional technical/surveyor services for works.
- Links to in-house practical (Home Maintenance) services for completion of works.
- Access to capital funding pots for minor/medium repairs/adaptations that are held or accessed by each Care & Repair Agency, and the £3 million WG funded Rapid Response Adaptations Programme (RRAP).
- Benevolent and charitable income sourced for works needed, where applicable.
- Prudent healthcare advice, including falls risk assessment.
- Access to Care & Repair's Hardship Fund for clients whose works cannot be funded by any other source
- Access to our bespoke Decluttering Fund exclusive to H2HH clients.
- Welfare Benefit checks and applications that increase patient's income.
- Support for patient access to Local Authority housing grants and community OT services.
- Referral-on to local statutory and third sector providers for assistance with care needs, loneliness, disabled rights, financial advice etc.
- Links to Care & Repair's Managing Better service- specialist casework support for clients with living with sight or hearing loss, dementia and for stroke survivors. This is delivered through WG Sustainable Social Services Grant, with our partner organisations Alzheimer's Wales, Stroke Association Cymru, RNIB Cymru and RNID Cymru.
- Links to our 70+ Cymru service and Home Energy Officers for expert advice and support for those living in cold homes or in fuel poverty.

A selection of case studies detailing the real-life work our H2HH caseworkers to on a daily basis to support hospital discharge across Wales is available here.

Hospital to a Healthier Home has developed experience of working in busy hospital environments, built strong partnerships and has links to a wide range of community services, where it can draw on resources to address barriers to a safe and effective discharge quickly. Its role as a co-ordinator and problem-solver, when NHS staff are under enormous pressure, and its ability to act flexibly and quickly, bringing with it some funding for key solutions is a critical factor in its success.

Despite this, the continuation of Hospital to a Healthier Home is now subject to individual discussions and applications to each LHB currently taking place, and at risk of ending, at least in parts of Wales, if these applications are not successful.

Appendix 1 – H2HH outcomes for April 2020 – March 2021



Appendix 2 – H2HH Outcomes for April 2021 – September 2021 (Q1 and Q2)