



Senedd Cymru Health and Social Care Committee consultation on Hospital Discharge and its Impact on Patient Flow Through Hospitals

Executive summary

The Royal College of Speech and Language Therapists (RCSLT) Wales welcomes the opportunity to provide written and oral evidence as part of the committee's inquiry on hospital discharge and its impact on patient flow through hospitals. Our response focusses on the key themes raised within the terms of reference and is based on discussions with our members across Wales.

Key points

- Our members report the main barriers and pressure points include capacity limitations within social care to support frail elderly patients in the community and across reablement services.
- Ongoing issues with regards to the nursing and the health and social care workforce is impacting on the ability to deliver speech and language therapy interventions in some areas as speech and language therapists (SLTs) are required to support ward staff with fundamentals of care. It is vital that Allied Health Professionals (AHPs) are protected from redeployment given their central role in enabling people to live well at home.
- A focus and investment in rehabilitation and community support programmes is also essential to effectively support the 'home first: discharge to recover and assess' pathway. There are positive discussions with regards the AHP role within primary care model but sustained funding is required.
- A strong recurrent theme from some health boards was that the need for neurorehabilitation was a significant contributory factor for patient delays, with patients sometimes experiencing protracted lengths of stay. Focus and investment in this area is required.

About the Royal College of Speech and Language Therapists

1. RCSLT is the professional body for speech and language therapists, SLT students and support workers working in the UK. The RCSLT has 17,500 members in the UK (650 in

Wales) representing approximately 95% of SLTs working in the UK (who are registered with the Health & Care Professions Council). We promote excellence in practice and influence health, education, care and justice policies.

2. Speech and language therapy manages the risk of harm and reduces functional impact for people with speech, language and communication support needs and/ or swallowing difficulties.
3. As part of emergency care and discharge planning, SLTs work closely with other services, such as physiotherapists and occupational therapists, to assess and support patients' needs. They help to prevent a cycle of emergency readmissions by working with individuals and their families to develop personalised strategies to manage their speech, language, communication and swallowing difficulties. For example, they develop feeding plans and daily exercises that patients can follow at home and that community-based staff can supervise. By developing personalised care plans, SLTs can help patients to understand their own health needs and support them to feel safe and confident when they return home.

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

4. Our members report that there are significant numbers of patients in acute hospital beds who are medically fit to leave hospital but who are currently unable to be discharged due to the lack of carers in the social care system. There is sustained demand and pressure in hospitals due to a combination of factors including the need to increase non-Covid activity whilst there continues to be sustained high level of Covid circulating in the community resulting in hospitalisations and self-isolation for the workforce. Ongoing issues with regard to the nursing and the health and social care workforce are impacting on the ability to deliver speech and language therapy interventions in some areas as SLTs are required to support ward staff with fundamentals of care. Length of stay is also impacted significantly by difficulties in securing care packages for patients who need them. In some hospitals pressure is so acute that we understand that senior leadership are considering closing/de-escalating non urgent services and redeploying staff.

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

5. From a system perspective, members report that delayed discharges impact on the number of beds available for admitting patients leading to longer waiting times in accident and emergency departments or cancellations of planned admissions. There is daily pressure on beds with the need to expedite discharge of transfer from acute to rehab sites. This affects the AHP workforce including speech and language therapy who have to prioritise patients who need discharge. Wards have also been re-configured to meet the needs of the patients admitted. For example, Covid vs non-Covid beds.
6. For individual patients, many of whom are over the age of 65, discharge delays can lead to poorer outcomes through the loss of independence, confidence and mobility, as well as risks of hospital acquired infections, re-admission to hospital or the need for long-term support.

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

7. Our members report that the main barrier for many services is the lack of capacity within the social care system to support frail, elderly patients in the community and the ability of social care carers to modify diet and/or fluids to enable people to return home safely.
8. Another key factor affecting discharge is the limited capacity within community rehabilitation services in some areas. Community rehabilitation services may be defined as;

‘assessment, advice and tailored rehabilitation support that takes place in settings outside of acute hospital wards and that improves people’s health and wellbeing. Community rehabilitation helps people with long term conditions, injuries or illness to live well for longer¹.’

Rehabilitation cuts across the health and social care systems supporting people in different settings, and often reducing the need for care and hospital admissions. It supports recipients to remain as independent as possible and participate in education, work, family life and their community and society as a whole. Community rehabilitation can improve recovery rates from illness and injury and thereby limit the level of social care needed after discharge from hospital. Community rehabilitation can also enable people to better self-manage their long-term conditions and slow the impact of degenerative diseases, both of which create knock on savings for social care budgets.

9. Our members tell us that despite the impact of high-quality rehabilitation on quality of life and long-term NHS and social care costs, community rehabilitation is often piecemeal and varies significantly depending where you live in Wales. In many cases, patients are only being referred to speech and language therapy for crisis management and there are missed opportunities to engage in advanced care planning and active treatment.
10. Our members have commented that often, community care packages do not provide the communication support required (in terms of numbers of hours needed for intervention, education and support by SLTs) as the capacity for independent living dwindles. These packages frequently do not recognise the need for older people to have adequate communication abilities and the need for adequate nutrition if swallowing is compromised. This also increases the demand on family members who also require support and education as how to best assist the older person to maintain the best functional ability at home. This situation is exacerbated by the impact of shielding and social isolation as a result of the pandemic.
11. These concerns about the availability of community rehabilitation provision are echoed in two recent reports by Senedd cross party groups. A 2020 report from the Stroke Association, based on evidence collated as part of the Stroke Cross Party Group inquiry, revealed that 21% of stroke survivors in Wales reported that they did not receive enough support after a stroke² with only a minority of stroke survivors receiving therapies at

¹ Community Rehabilitation Alliance (2020). Live Well for Longer. Available [here](#)

² Stroke Association (2018), Lived Experience of Stroke - Chapter 4 Rebuilding lives after stroke, 2018. Available:

https://www.stroke.org.uk/sites/default/files/leos_one_pager_wales_chapter_4.pdf

guideline levels³. The report recommends that ‘Health boards must take immediate steps to improve their therapy provision and bring delivery of therapies closer to RCP guidelines.’⁴

12. The Wales Neurological Alliance has also recently undertaken an inquiry into the impact of the Welsh Government’s neurological delivery plan. The report recognises that there has been investment in neurological rehabilitation but highlighted that there remain low levels of availability of community services stating;

‘Many poor experiences were described by contributors, in particular in relation to a lack of availability of community-based services such as physiotherapy, speech and language therapy, occupational therapy, continence advice and support, services that help people to be physically active, mental health services and emotional support.’⁵

13. We welcome the drive towards integration and an increasing focus on moving services closer to home. We are pleased to have recently joined the AHP leadership group for the Strategic Primary Care Programme. A number of speech and language therapy services have been able to benefit from monies under the Integrated Care Fund (ICF) with the aim of supporting those with swallowing and communication difficulties to keep safe and well at home including within care-home settings. However, funding streams such as the ICF are often very short-term which can lead to recruitment challenges. The AHP Framework for Wales recognises that;

‘too often, short term innovations in the AHP services have been established as pilots without long term sustainable funding in place. This has limited the opportunity to scale up and support wider adoption across Wales when innovations as detailed above are proven to be effective’⁶.

We strongly recommend that those interventions that deliver high value outcomes are identified and adopted across Wales to improve community rehabilitation services as a key enabler in supporting discharge and reducing hospital admissions. A focus and investment in rehabilitation and community support programmes is also key to the implementation of the ‘home first: discharge to recover and assess’ pathway.

14. A strong recurrent theme from some health boards was that the need for neurorehabilitation was a significant contributory factor in patient delays, with patients sometimes experiencing protracted lengths of stay.
15. Specialist rehabilitation services play a vital role in the management of patients admitted to hospital by supporting patients after their immediate medical and surgical needs have been met, and maximising their recovery and supporting safe transition back to the community. As our population continues to grow and life expectancy increases, the number of people with a neurological condition will continue to rise. Neurological conditions vary widely in terms of their impact; they include progressive, incurable conditions, stable conditions, and

⁴ Stroke Cross Party Group (2020). The Future of Stroke Care in Wales: report of the inquiry into the implementation of the Welsh Government’s Stroke Delivery Plan.

⁵ Cross Party Group on Neurological Conditions (2020). *Building the foundations for change: The impact of the Welsh Government’s Neurological Delivery Plan*

⁶ Welsh Government (2019). Allied Health Professional Framework for Wales. Available here: <https://gov.wales/sites/default/files/publications/2020-02/allied-health-professions-framwework-for-wales.pdf>

also sudden-onset neurological incidents that can severely affect a person's life. The complex nature of these conditions means that professionals require specific expertise and training to diagnose and manage them, the specialist care enables the provision of expert knowledge, tailored care planning, care integration and multidisciplinary working. Failing to access specialist care can lead to poorer outcomes for people affected by neurological conditions and put pressure on other parts of the health and social care system.

16. Specifically, it has inferred by members that the lack of inpatient neuro rehabilitation beds (level 2) means that provisioning the rising demand for inpatient neuro rehabilitation is very challenging. As a result patients may experience substantially delayed transfers of care in acute hospitals due to waits in accessing inpatient neuro-rehabilitation.

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

17. We wish to highlight a number of developments of interest which relate to our view of the whole-system approach which is required to improve patient flow, maximising the usage of AHPs.

Sandwell and West Birmingham Trust's 'rapid response therapy team'

SLTs play a crucial role in Sandwell and West Birmingham Trust's 'rapid response therapy team'. They work alongside other AHPs and attend A&E to:

- prevent unnecessary hospital admissions, via a highly responsive service that operates 12 hours a day, 365 days a year to assess patient needs.
- work collaboratively with social work colleagues to support the patient to return home.
- deliver urgent speech and language therapy assessment within three hours in community, to ensure patients' swallowing can be managed at home by community staff.

SLTs have helped to reduce costs and improve patient outcomes at the Trust by providing intensive therapy to ensure patients start eating and drinking as soon as possible to avoid the use of tube feeding and allow a safe return home with community speech and language therapy support. As part of an integrated care approach, they also work closely with the discharging and community teams to ensure patients identified as at risk of readmission receive appropriate support in the home setting, and are psychologically and physically prepared to return home. The Trust's integrated care service has helped to relieve winter pressures on A&E services and create financial savings and improved outcomes for patients. As a consequence, it has reduced hospital admissions by 2,478 per year, reduced length of stay in hospital from 10 days to seven days, and saved approximately 17,000 bed days, which has the potential to reduce costs by more than £7 million.

Cardiff and Vale University Health Board SLTs at the front door at A&E

Attending an emergency department is associated with a high risk of admission for older people, who are admitted to hospital more frequently and then stay in hospital longer than other patients. Having SLTs at the 'front door' of A&E departments enables them to make rapid interventions to ensure that people are admitted to hospital only for urgent medical care. During the integrated

therapy project which spanned 3 months, the following outcomes were achieved thus demonstrating the need for and benefits of speech and language therapy input prior to admission to the ward.

- **17** admissions were prevented in the Assessment Unit (AU), which were led by SLT. Close liaison with the Community Resource Team SLT Team was essential, as they could provide support on the day of discharge.
- **67** chest infections prevented by SLTs in AU, saving **£102,912**.
- A review of length of admission for those admitted with a chest infection was undertaken for the second month of the project. The mean length of stay was 5.8 days. If this were to be the average for the year this would represent an additional cost saving of an average of 8.4 bed days saved per person which would equate to a saving of **£20,508**.
- The projected annual saving would be **£998,748**.

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.

18. Delayed transfers of care are multifactorial so no single intervention will provide overall success. A whole-system approach is needed. AHPs' skills are required in order to help people remain at home, at the front door of hospitals, supporting timely discharge and enabling successful transitions back into the community. Professor David Oliver, Visiting Fellow from The King's Fund has stated that

'AHPs are critical in getting patients back to their own home quickly from the front door of the hospital and ensuring good inpatient rehabilitation and discharge planning.'⁷

19. The RCSLT firmly believes that multidisciplinary admission and discharge teams across the hospital environment should include SLTs, with therapy led discharge planning for people with complex health care needs. When planning the configuration of services, it is vital to ensure that the right professionals with the right skills are employed to meet the needs of the local population.
20. We are concerned at reports that redeployment of AHPs is once more being considered to bolster workforce challenges with regard to nursing and health care support workers, particularly given the importance of AHPs to successful discharge planning.
21. During the first wave of the COVID-19 pandemic, the RCSLT supported appropriate redeployment of SLTs into other roles. Our members were keen to volunteer at this time of national crisis. However, 21 months later we have seen the impact that the pandemic, including this period of redeployment, has had on speech and language therapy services and the people who rely on them. Given these risks, we do not support the redeployment of SLTs away from services that are already under extreme pressure as they attempt to restore services, reduce waiting lists and meet targets. We believe that there are more cost-effective alternatives that have been used successfully in some areas and could be used more widely, for example bringing back retired staff or using volunteers or students to increase system capacity.

Further information

⁷ <https://www.kingsfund.org.uk/about-us/whos-who/david-oliver>

22. We hope this paper will be helpful in supporting the committee discussions around discharge and patient flow. We would be happy to provide further information if this would be of benefit. Please see below our contact details.

Confirmation

This response is submitted on behalf of The Royal College of Speech and Language Therapists in Wales. We confirm that we are happy for this response to be made public.