Royal College of Nursing Wales response to the Health, Social Care & Sport Committee's inquiry into the Hospital Discharge Processes

The Royal College of Nursing Wales is grateful for the opportunity to respond to this consultation. The Royal College of Nursing Wales would be happy to provide oral evidence to the committee if requested.

Overview

NHS performance statistics in Wales[1] show that in 2019, on average 452 patients remained in acute NHS beds despite being medically fit for discharge. An average of 194 patients were waiting for community care and 69% of patients were aged 75-years old or older.

The acute hospital environment is not beneficial for people to remain in longer than clinically necessary. There is an increased risk of infection and a growth of mental dependency. Physical abilities decline rapidly which then result in an increased likelihood of falls and further injury.

The "Get Up, Get Dressed, Get Moving" campaign acknowledged that patients aged over 80 who remain in bed lose up to 10% of their muscle mass in just 10 days. This equates to their muscles ageing by about 10 years. The Campaign noted that up to 50% of patients can become incontinent within 24 hours of admission and fewer than 50% of patients recover to preadmission levels within 1 year[2].

The most significant factor causing delays in discharge is the lack of capacity in the community to receive adult and child patients. There are not enough nurses in the

[1] Stats Wales, 2019, Delays in Transfer of Care, https://statswales.gov.wales/Catalogue/Health-and-Social-Care/NHS-Performance/Delayed-Transfers-of-Care/delayreason-by-localauthority
[2] Get up, get dressed, get moving, 2018, Cardiff and the Vale, http://www.cardiffandvaleuhb.wales.nhs.uk/get-up-get-dressed-get-moving

community to care specifically for children and there is a lack of resources to care for individuals with mental health needs.

Effective rehabilitation and recovery takes time and extra care and assistance. This may be clinical e.g. wound dressing, pain management and monitoring infection. It may be assistance with daily living such as hygiene, toileting and meal preparation. The mantra of 'people should be cared for at home' must be balanced with an understanding of whether the home environment is suitable. A home environment may be unsuitable because physical limitations that cannot be altered e.g. stairs, or there may be family arrangements that also require rearrangement e.g. if the recovering person is usually a full-time carer.

The type of capacity that is required in the community includes: social work support, support for physical adaptions and equipment, community nursing and beds in care homes for temporary placements.

This is especially true for those with a mental health diagnosis, learning difficulty or a complex condition as a child. Individuals with learning disabilities or a mental health diagnosis often experience a delay in discharge due to the lack of care providers available to provide the level of specialist care that the patient requires. The lack of capacity in the community to care for individuals with specific needs and demands prevents a timely discharge.

Having supervisory ward sisters, sufficient nursing staff in general and access to a specialist discharge liaison nurse are all beneficial factors as are sufficient pharmacy staff, occupational therapists, physiotherapists and patient transfer/ambulance staff alongside streamlining bureaucratic procedures.

The second significant factor in delayed discharges is lack of nursing and staff capacity to organise the discharge effectively and plan for this from the point of admission. This is present in adult, child and mental health discharge.

Royal College of Nursing recommendations to improve the hospital discharge process

- An increase in nursing care beds for temporary placement in each Health Board
- An increase in capacity for multidisciplinary teams (MDT) based in the community and integrated between the local authority and Health Board to support the discharge process.
- Health Boards should support the role of the discharge liaison nurse

- Health Boards should ensure the fully supervisory nature of the ward sister/charge nurse role.
- HEIW, NHS Wales and the Welsh Government should work together to increase the number of children and learning disability registered nurses in the community.

How delayed transfers of care are measured

A Delayed Transfer of Care (DTOC) census captures a monthly snapshot of data retaining to patients who are medical fit for discharge but are delayed from leaving the hospital. Although this census is welcomed as it provides evidence on an important process, it does not provide a complete picture

- It fails to identify individuals who fall between the census dates.
- It does not capture the number of patients who are waiting for longer than a month. For example, in 2017 a DTOC patient who had a serious mental health condition, learning disability and physical health problems was finally discharged after a 4-year wait[3].

The DTOC census should be adapted to identify time spent waiting.

Why do delayed transfers of care occur?

The most significant factor causing delays in discharge is the lack of capacity in the community to receive patients.

Community Care

Recovery from hospital-based treatment requires clinical and social support. This package of care requires planning and of course the actual capacity to deliver. In addition, some of our most vulnerable older people are supported 365 days of the year by community nursing delivering complex care and treatment packages at home. If this package of care is interrupted by a hospital admission then there can be a delay in restarting this process.

Of course, without adequate support the risk of readmission becomes higher due to falls, poor nutrition, infection etc.

[3] Wales Online, 2017, Patient spends four years waiting for hospital discharge, https://www.walesonline.co.uk/news/health/patient-spends-four-years-waiting-12935263

A temporary or permanent placement in a care home may be required. The financial burden on the elderly patient and their families may delay, the transition from the hospital setting into a care home facility. Furthermore, identifying a bed in a care home is a lengthy process and is often followed by a complex funding process.

- The time it takes have equipment provided e.g. temporary mobility aids
- The time it takes to make necessary adjustments and structural change to a home (e.g. a ramp)
- The assessment for and availability of care packages to support home living e.g. daily visits from community nursing and/or domiciliary care workers
- The time taken to identify arrange and fund a suitable placement in a care home.

There is also a shortage of district and community nursing, with a steep decline since 2013/2014[4]. Age Cymru (2019) acknowledge community nurses play an essential role in older people's healthcare, delivering acute, complex and end-of-life care, in addition to preventative services which help older people maintain independence[5].

The Health Foundation has estimated that an additional 7,000 FTE nurses will be needed in community health by 2023/2024[6].

Child Community Care

Most children with complex needs receive care in the community as do those recovering from treatment or operations. Despite this, there are few nurses in the community to specifically care for children with complex conditions. Stats Wales reported in December 2019 that there were as few as 48 children nurses in community services[7].

Child services has thus fallen into the work of most community Registered nurses. Community nurses work in a variety of roles and setting spanning across child and adult care.

Traditionally Children's Nurses were relatively few in number and hospital based. These days' children with complex health needs can receive far more care at home. This means many more Children's Nurses are needed in the community. Wound care & management,

[4] NHS Digital (2019). NHS Workforce Statistics*: March 2019.* Available at: https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics/nhs-workforce-statistics---march-2019-provisional-statistics
[5]Age Cymru, 2019, Consultation response and submission, https://www.ageuk.org.uk/globalassets/age-uk/documents/reports-and-publications/consultation-responses-and-submissions/health--wellbeing/age_uk_evidence_to_the_health_and_social_care_committee_august2019.pdf
[6] Health Foundation, 2019, Investing in the NHS Long term plan.
[7] https://statswales.gov.wales/Catalogue/Health-and-Social-Care/NHS-Staff/Non-Medical-Staff/nursingmidwiferyandhealthvisitingstaff-by-grade-areaofwork-year

ventilation, BP monitoring, IV medication/ line management, enteral feeding support and palliative care are some of the services Children's Nurses provide, along with vital education for other healthcare professionals and for carers and school staff. Learning Disability Nurses are also in very short supply and are needed to support children and young people with challenging needs.

The Welsh Government, HEIW and NHS Wales should work together to increase the number of Children's Nurses in community nursing. This would improve the hospital discharge process and reduce readmission.

Is there an infrastructure and staff awareness to ensure the effective delivery of these processes?

There is excellent awareness in the registered nursing profession of an effective discharge process. This is part of the pre-registration curriculum and an essential part of the nursing role both in the hospital and the community.

The difficulty lies in carrying out an effective discharge process (including planning for this from the point of admission) when nurse staffing levels are diminished.

Nursing staff are placed under significant pressure to safely plan for hospital discharge and liaise with other professionals, whilst simultaneously treating a high volume of acute patients. When numbers of registered nurses fall on a ward hospital discharge planning can be delayed as the treatment of acute patients is prioritised.

NICE Guidelines on Bed occupancy (2018)[8] and National Audit Office found that bed occupancy levels above 85% will lead to bed shortages, periodic bed crisis and an increase in hospital acquired infections. In Wales, our health boards that provided acute care have bed occupancy exceeding 85% year on year. Stats Wales (2018/19) reported the following[9]:

- Aneurin Bevan 86.5%
- Betsi 86.5%
- Cardiff 87.9%
- Cwm Taf Morgannwg 85.4%
- Hywel Dda 88.3%

[8] NICE guidance, 2018, Chapter 39 Bed Occupancy, https://www.nice.org.uk/guidance/ng94/evidence/39.bed-occupancy-pdf-172397464704
[9] Stats Wales, 2019, Bed Occupancy by organisation and site, https://statswales.gov.wales/Catalogue/Health-and-Social-Care/NHS-Hospital-Activity/NHS-Beds/nhsbeds-by-organisation-site.

- Swansea Bay 87.2%

Welsh health boards are in a continual state of bed shortages. A reduction in bed numbers alongside an increase in bed occupancy has led to pressure in the system with staff being challenged to find beds for patients, surgeries being cancelled, and patients being discharged unsafely with readmissions within 28 days.

Nurses have reported being under pressure to discharge patients who they felt were not ready to go home. If patients being discharged too early that often results in readmission within 28 days.

Having supervisory ward sisters, sufficient nursing staff in general and reducing reliance on agency nursing (which are likely to be unfamiliar with local discharge arrangements) are all beneficial factors to an effective process.

Access to a specialist discharge liaison nurse is extremely helpful as sufficient pharmacy staff, occupational therapists, physiotherapists and patient transfer/ambulance staff alongside streamlining bureaucratic procedures.

Nursing staff, specifically discharge liaison nurses, are the champions of safe and appropriate discharge, but an effective discharge is everyone's responsibility.

The experiences of patients, families, carers and staff of discharge processes.

The statistics and performance measures collected by the Welsh Government currently do not include patients' experiences of discharge.

The Royal College of Nursing would support patients' experience evidence being gathered by the Welsh Government.

The importance of patient's experience has been recognised within the nursing profession and local health boards. *'Patient stories'* are often collected by nurses and used to illustrate an experience and reflect upon. The patient's story is shared with a group of nursing professionals with the aim to improve practices. Health board similarly gather patient stories and reflect upon them at their Board meeting, this is also done to improve practise.

The examples below are drawn from our members experience and illustrate some of the common concerns that we have explained elsewhere in the paper.

<u>Example A – a too early discharge</u>

A patient who had been admitted to hospital for surgery was due to be discharged on a Saturday. She was instead discharged late on Friday and a surgical drain had been removed even though it was still draining. The wound leaked overnight, and the bedding had to be changed 3 times. By Monday she was sent back to hospital by her GP. Following her experience, she developed abdominal collection, wound infection and sepsis. The patient expressed that she waited hours for another bed to be available and was admitted for a further three weeks.

Example B – a delayed discharge

A patient who has undergone knee surgery was judged medically fit to be discharged on Wednesday. A physiotherapist was needed to asses mobility. The physiotherapist was able to see the patient on Friday. Some mobility aids were required for the home. Only an occupational therapist could issue these. The occupational therapist was able to see the patient on Monday and issue this equipment. An ambulance was booked to take the patient home on the Tuesday at 12noon. The patient was asked to leave the bed and sit in the discharge lounge at 9am so the bed could be free for another patient. A suitable wheelchair was found only at 11am. However, at this point there was no chair free in the discharge lounge so the patient remained in the bed. When the ambulance transfer team arrived at 12noon the patient's medication was not ready. The pharmacy advised the patient stay an extra night as the medication would be ready the next day. The ambulance transfer would need to be re-booked and the next available slot was Thursday. Thus, the total number of days delayed in hospital since the patient was ready for discharge was 7 days.

Example C- A mental health nurse discharge experience

Two individual patients, one had a learning disability and the other a mental health diagnosis, were awaiting a discharge from an assessment and treatment unit (AATU). Care providers had been agreed and went through the transition process and at times commenced their own care staff to begin shadow shifts with these individuals. The care providers then decided they could not meet the needs for these individuals The mental health nurse expressed that they find it extremely hard to deal with the failure to discharge as it leaves the most vulnerable patients back to square one in an AATU despite being ready for discharge and these instances have an impact on the patient's mental state which can cause a relapse.

What are the barriers and enablers to effective communication and joint working between health, social care and third sector bodies?

The significant barrier that prohibit effective communication and joint working between health, social care and third sector bodies is funding and the lack of staffing and resources. As previously noted, social care funding has a significant impact on the hospital discharge process for the NHS, patient and families and the third sector. The NHS and local authorities need to ensure decisions are made on an individual case, this can be expensive and time consuming.

Social care staff may also be working on a weekday 9 to 5 pattern which can hinder communication with healthcare. An increased focus and revised vision of primary, social and community care, with an emphasis on the community nurse would improve communication and breakdown the barriers to joint-up working.

A key enabler to improve communication is to increase local partnerships**.** Local partnerships are essential for effective communication. Teams being co-located has been shown to be an enabler to good communication.

Another enabler is multi-disciplinary teams (MDTs). MDTs work across primary, secondary and community care and are important for enhancing communication and joint-up working. The teams include various medical professions that are tasked with working together to improve the care provided for a patient.

Solutions and initiatives that work, enabling effective, appropriate and timely hospital discharge; how these are rolled out and mainstreamed.

The Royal College of Nursing recommends supporting the role of the specialist discharge liaison nurse. This is a specialist nursing role that is pivotal to ensuring that the discharge of patients *with complex needs* is effective and efficient.

Discharge liaison nurses:

- ensures patients with complex care can leave hospital as soon as it is appropriate, rather than staying in an environment that is not designed to care for people with ongoing complex needs.
- provides expert advice and advocacy for the patient, their carers, relatives and friends.
- ensures the patient has safe and appropriate plan of care for when they leave hospital.

- provides a coordinating role and liaises between the patient, family members, community nurse, GP and social worker to ensure that all appropriate people are able to contribute to the ongoing plan of care.
- ensures that the hospital bed is made available in a timely and planned way for the next person who needs it and avoids delays in Accident and Emergency.
- ensures the ward sister or charge nurse does not waste valuable time struggling to discharge a complex patient, that should be spent attending to the clinical needs of every patient in their care.
- ensures that front line nursing teams have the additional knowledge and skills necessary to plan the ongoing care of the increasingly complex patients that are being admitted to our hospitals.

Ensuring the Nurse Staffing Levels (Wales) Act 2016 is implemented and extended

Section 25A of the Nurse Staffing Levels (Wales) Act 2016 Act states that each Local Health Board must have regard to the importance of providing sufficient nurses to allow the nurses time to care for patients sensitively wherever nursing care is provided or commissioned. Caring for patients sensitively would include planning an effective discharge process.

The Royal College of Nursing would recommend that discharge planning is included in any audit of compliance with this duty of the Act and this factor is included in an improved approach to performance management of delayed discharge.

The operational guidance underlying the duties of the Act in Section 25B recommends the position of the ward sister/charge nurse is fully supervisory. This allows for planning and oversight of discharge arrangements. Progress and Challenge a report published by RCN looking at the implementation of the Act[10] found evidence that although health boards were investing in this area the ward sister/charge nurse role was rarely fully supervisory in nature. This factor should be identified in performance management of delayed discharges.

The Welsh Government should extend Section 25B of the Nurse Staffing Levels (Wales) Act 2016 to community nursing services. The expansion of this section to community nursing would support the discharge of patients in a timely manner into the community. It would further allow the patient to receive care in a more desirable environment and reduce hospital

[10] Progress and Challenge: the implementation of the Nurse Staffing levels (Wales) Act 2016 RCN Wales November 2019.

readmission. The Health Foundation has estimated that an additional 7,000 FTE nurses will be needed in community health by 2023/2024[11].

About the Royal College of Nursing (RCN)

The RCN is the world's largest professional organisation and trade union of nurses, representing around 435,000 nurses, midwives, health visitors, healthcare support workers and nursing students, including over 25,000 members in Wales. RCN members work in both the independent sector and the NHS. Around two-thirds of our members are based in the community. The RCN is a UK-wide organisation, with its own National Boards for Wales, Scotland and Northern Ireland.

The RCN represents nurses and nursing, promotes excellence in nursing practice and shapes health and social care policy.

[11] Health Foundation, 2019, Investing in the NHS Long term plan.