HDP07
Ymchwiliad i brosesau ryddhau o'r ysbyty
Inquiry into hospital discharge processes
Ymateb gan Gymdeithas Cludiant Cymunedol
Response from Community Transport Association

Health, Social Care and Sport committee inquiry into the hospital discharge process

A response from the Community Transport Association

This response is submitted by the Community Transport Association (CTA), a UK-wide charity working with thousands of other charities and community groups across the UK which provide local transport services that fulfil a social purpose and community benefit. We support community transport operators across Wales and work with a range of key stakeholders to champion the sector and raise standards. Community transport helps to address the quality, affordability and accessibility of transport options for people who cannot drive and do not have access to conventional public transport. It is about providing flexible and accessible community-led solutions in response to unmet local transport needs and often represents the only means of transport for many vulnerable and isolated people.

Background

The Health, Social Care and Sport Committee is undertaking an inquiry into the hospital discharge process focusing specifically on delayed transfers of care. This response is informed by the experiences of community transport operators in Wales and outlines the challenges for our members in providing transport for those being discharged from a healthcare setting. In our response, we have provided evidence against the areas outlined in the terms of reference that are most relevant to us.

Detailed response

What are the experiences of patients, families, carers and staff of discharge processes?

Transport is something that we so often take for granted and yet it is central to our everyday lives and creates significant challenges for those who face barriers to accessing transport. Of course, a key component of the hospital discharge process is the journey home. For many, there are family members or friends able to provide support but others may call upon community transport services to help them transfer back to their home and community.

To give an example, PIVOT (Pembrokeshire Intermediate Voluntary Organisations Team) brings together voluntary organisations to prevent inappropriate hospital admissions, facilitate early discharge and reduce support required from statutory agencies. This service is able to provide support on the occasions where Welsh Ambulance Services Trust (WAST) transport is not appropriate or not available such as evenings or weekends. Generally, this would be for patients who have had a short stay in hospital or to prevent emergency admission rather than for Delayed Transfers of Care (DTOC) cases. In these circumstances, there would not have been time to arrange hospital discharge transport via WAST so the referral to Community Transport ensures the patient is discharged home quickly.

For cases where patients require support and assistance settling back in to their own home, PIVOT is able to provide a holistic approach through a network of partners to ensure the patient has access to a wider range of support than just their journey home from hospital. Small home adaptations, access to mobility aids, connection to befriending services, and referrals to ongoing transport support all ensure that the patient's needs are met and the likelihood of readmission is reduced. We know that Community Transport is often more than just a bus ride home.

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

In terms of challenges faced by community transport operators in working with health & social care providers around discharge transport, feedback from our members identifies a number of barriers and enablers that are important to note. These are as follows:

Delays

Often there are delays associated with hospital discharge which make it challenging to plan the necessary transport. For example, waiting for medicines to be dispensed frequently holds up the process when the patient is ready and waiting to go home. Making discharge a smooth and joined-up process would remove unnecessary delays along the way.

Recommendation 1: Health services should ensure a joined up approach to prevent any delays at the point of discharge.

Transport

Seamless transfer from a care setting back home requires good information about the patient and their needs to be provided for the operator so they can make sure they provide the necessary support. These include:

- Knowledge of mobility requirements, particularly any that affect the patient's ability to board the vehicle.
- Information about their home situation that the community transport operator needs to know such as the level of support available at home, whether or not someone is due to be meeting them at the house and so on.
- Any access requirements for the home (such as steps) which may not have been a problem before the patient went into hospital but a barrier to access once they come out. Our members report that this is a common issue in transferring a patient back into their home.
- Issues created if a patient is using a wheelchair for the first time. Most community transport vehicles are wheelchair accessible but the home needs to be assessed for access along with support for additional needs where a patient's mobility is compromised. Members have shared examples with us where properties are inaccessible for a wheelchair due to steps and paramedics have had to carry the patient into the home.

Planning transport for discharge needs to be taken into account as part of the process and should consider the whole journey including getting to the vehicle and into the house at the other end. Where discharge is planned and mobility needs are complex, a risk assessment should be carried out at the home address to identify and mitigate any potential issues. If this is already in place, transport and access issues could be included in this.

Recommendation 2: Ensure all access and mobility needs, including wrap-around aspects of a patient journey, are taken into account when planning for hospital discharge.

Additional support

Members report that drivers play a key role in supporting the mental health and wellbeing of patients we transport home. Many patients are anxious about going home and will open up to our drivers on the journey back in a way that they may not have done to healthcare professionals in hospital. Recognition of the role drivers play and support for that is important in transferring the patient successfully back home.

It is important to understand the support the patient has at home and make sure needs are met following hospital discharge. Additional care may be needed for patients who live alone or do not have support at home. Patients may be reliant on unpaid carers or they may live with other frail or vulnerable family members so making sure appropriate support

is in place should be central to the discharge planning process. A report published by the Red Cross on hospital discharge supports our analysis and recommends a 5-part independence check which we support[1]. This ensures all aspects of life are considered and supported through the discharge process.

The discharge process should recognise the added value that community transport offers compared to other transport options. Community transport is far more than just a journey, offering bespoke physical, mental and emotional support for the individual to travel home and settle back in.

Consideration should also be given to the support required after the patient arrives home in the first days and weeks post-discharge. From the point of view of our members, this might be travel to appointments, support to go shopping, access support groups or similar. Even in the situation where community transport was not involved in transporting the patient home, it might well be appropriate to refer the patient on to the local community transport operator to ensure support for accessing services following discharge from hospital.

Community transport has a vital role to play in helping people to live independently at home and this should be recognised by the health authorities in order to ensure people are supported to remain in their own homes for as long as possible.

Recommendation 3: Services should recognise the critical role community transport plays in supporting patients to return home and live independently.

COVID19

Members have raised challenges regarding early discharge due to COVID19 in recent months. In this circumstance, it is especially important to ensure proper care and support is in place for the patient after they return home.

Recommendation 4: Ensure patients have appropriate support in place for a successful early discharge to reduce pressure on external services.

For further information, please contact:

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[1] British Red Cross, *Home to the Unknown: Getting hospital discharge right,* London