

Hospital discharge and its impact on patient flow through hospitals

CIH Cymru inquiry response

This is a response to the Senedd's Health and Social Care committee's inquiry focussing on hospital discharge and its impact on patient flow through hospitals.

1. Introduction

- 1.1 The pandemic has brought into sharp focus what the impact of having an affordable, safe place to call home can have on people's ability to remain safe and well. The pandemic has already highlighted the stark differences in people's experiences that find their roots in their housing circumstances. For some the pandemic has provided a chance to spend more time at home, save money, find a better work/life balance whilst enjoying a comfortable home environment. For others who live in poor housing conditions, in overcrowded homes or suffer domestic violence/abuse – being confined to their homes will have been a miserable experience, often making their circumstances even worse.
- 1.2 The role of housing in supporting various activities across health and social care has long been established as a vital part of meeting people's holistic needs. Whilst there is positive progress in ensuring housing is seen as a key partner in supporting patients and carers, the experiences of our members reflects that the recognition of housing's importance can be patchy, with access to the right professionals/teams, the availability of resources to support both the creation and sustainment of effective services a real challenge in practice.
- 1.3 As part of our effort to build a solid evidence base to support the creation of progressive housing policy, our Tyfu Tai Cymru (TTC) project has been operating for almost 5 years, highlighting how approaches in a number of areas relating to meeting people's housing and care needs could be improved. Two reports produced through TTC are of particular relevance to this inquiry:
 - [*Good health brought home*](#) – A study of successful collaborations between health, housing and social care identifying the common characteristics of the partnerships that increase the likelihood of success.
 - [*From hospital to home; planning the discharge journey*](#) – In-depth research based on insights from professionals, patients and carers on the positive impact housing advice can play in supporting effective hospital discharge, and the consequences when opportunities are missed to ensure patients have a suitable home environment.



1.4 Our evidence in the following sections reflects both our own evidence base and the insight gained from our membership of 900 housing professionals working across housing associations, local authorities and the private rented sector in Wales.

2. How housing advice is considered

2.1 Our 'From hospital to home: planning the discharge journey' (H2H) research published in July 2021, provided insights into how delays in patients leaving hospital could affect their ongoing care and well-being.

2.2 Our research identified a key concern being the lack of a singular definition of housing advice and that having a clear agreed definition would be a useful approach, although housing advice is provided in a number of ways. In our research, interviewees in our research agreed with a broad definition of housing advice (which has been adapted from one developed by Care & Repair Cymru) is :

"Housing advice refers to the provision of expert, comprehensive and integrated information about housing, care, financial matters and support aimed at enabling access to appropriate housing and maintaining the suitability and sustainability of a person's home."

We found that housing advice is usually dispensed across professional disciplines. That advice in the main would usually come via:

- Multi-disciplinary hospital discharge teams
- Local authority housing options staff
- Nursing staff

2.3 Whilst there was not an expectation that staff should have particularly in-depth or expert housing knowledge, there was an expectation from the respondents interviewed for necessary and timely referrals and notifications to be made that ensured that the best housing advice could be provided by the most appropriate people to patients, when they needed it.

2.4 The existence or use of a protocol or procedure was not regularly mentioned in our research interviews and where they were mentioned interviewees noted 'it wasn't really followed'. Other interviewees indicated that their approach to discharge planning was more down to an embedded practice and culture.

3. Variation in embedding housing advice/support

3.1 Our H2H research indicated that Hospitals, Health Boards and Local Authorities each took different approaches to addressing hospital discharge. Some had developed their own Social Work Hospital Discharge Teams, whilst others created a range of teams or team roles, including a First Point of Contact Team, Patient Flow Coordinators, Mental Health link workers, Discharge Solutions Officers, Occupational Therapy led discharge teams and individual specialist posts.



- 3.2 Some hospital discharge staff noted that their subsequent involvement with relevant housing bodies relied on well-established health-based professionals in a hospital setting, who often played a key role in holding the process together and in linking up the relevant community-based services in a timely manner.
- 3.3 Whilst expert housing staff were seen as highly impactful and a positive resource for teams to draw-on, there was some reflection in our work for the need to ensure housing is considered as a key area of focus by anyone involved in coordinating effective discharge.
- 3.4 These challenges focused on staff developing an over reliance on expert advice contained within a limited resource (one individual/post), or by having the knock-on effect of deskilling staff, by taking them away from regular involvement in needs assessment, advice provision or discharge planning.
- 3.5 Although not specifically mentioned by interviewees, the impact of gaps in service provision created by 'expert' professionals moving on and leaving posts (and any associated impact on effective discharge planning) was apparent to our interview team. Staff in community-based services, dealing with hospitals without dedicated teams or established health professionals coordinating discharge, reported problems of not having a known point of contact.
- 4. Barriers to effective use of housing advice**
- 4.1 The process of identifying patient needs linked to providing holistic care was considered an issue by most interviewees, causing challenges in practice, including:
- Concerns from some staff that patients may sometimes withhold or distort information in the interest of being able to leave the hospital environment (impacting arrangements for ongoing care)
 - Patients are not always well enough or have capacity to discuss their needs or situation, especially soon after admission and it was not clear in our interviews how these needs were addressed.
 - Prior to being admitted, mental health 'patients' are sometimes assessed over a period of hours/days, found not 'eligible' for treatment, and then 'discharged'. If these patients are unable to return to the home they may have left, they leave with an immediate housing need and without formal discharge planning taking place.
- 4.2 A number of interviewees noted that the 'complexity' of a patient's discharge requirements impacted on being able to achieve a timely and appropriate discharge. This may be due to there being a lack of clarity in establishing the housing circumstances, or through not having involvement or input from family or carers (whose views may not have been sought), or where patients were not previously known to health staff, or where patients may have specific



physical or mental health related conditions that impacted upon the discharge arrangements.

- 4.3 Some complex (which could result in unsafe) discharge were described by respondents as situations where:
- The patients' needs change throughout their stay in hospital meaning their previous accommodation is no longer suitable, at all, or in its previous form.
 - Special equipment such as hoists being required which in turn requires adequate space to be operated safely and effectively;
 - Cases involving hoarding or other health and safety factors, such as a property's electrical wiring hazards;
 - Family not being willing to take a patient back into their own home environment, principally on account of mental health needs, but also as a consequence of the patient's ongoing and unique psychological needs
5. **Help and advice for family and carers**
- 5.1 From the interviews we undertook through our H2H research with carers relating to the involvement of the patient and carer in assessing housing need/in the planning of hospital discharge arrangements, a consistent view was that 'discharge is always an issue.'
- 5.2 Even though the Social Services and Wellbeing (Wales) Act 2014 provides carers with a legal framework for their voices to be heard (through entitlement to a Carer's Assessment), discharge remains a 'post code Lottery', dependent on available facilities/ resources and being reliant on who may be involved in the planning process.
- 5.3 It is not clear from a carer perspective whether all needs, including housing needs are fully considered and it is arguable that COVID-19 pressures, to discharge people from hospital beds, exacerbated this.
- 5.4 Experiences from carers appear to indicate that people are often discharged from hospital to the care of family. In our survey 68% of respondents indicated that 'partner or family' were the main persons involved at the 'receiving end' of the hospital discharge arrangements, often having to lead on ensuring the housing environment was suitable for a discharge home.
- 5.5 Discharge often focuses on the patient's expectations, which is positive, but can mean that discharge planning is driven by patients being 'desperate' (in the words of one carer representative) to leave hospital. This may also be exacerbated by pressures from health services to discharge people, particularly during acute pressure points during the COVID-19 pandemic.
- 5.6 Unsafe discharge remains a concern for carers, particularly where there may be concerns around the age/physical needs of a patient, or where housing needs to be fully considered in relation to the home environment people may be discharged to. Interviewees were clear that discharge should start from



when people are admitted and that housing advice, or work to address the housing needs of the patient should form a key element of that work.

6, Ensuring effective links between staff and services

- 6.1 In our H2H research it was felt that the presence of expert staff in health settings raises both the profile and importance of providing appropriate and tailored housing advice in addressing the wider needs (above the clinical needs) that patients may have. Input from staff with housing expertise can complement and support health professionals in meeting patient needs in a holistic way and facilitate successful hospital discharge taking place.
- 6.2 Our research indicated that a multidisciplinary team (MDT) approach, with the involvement of key professionals was an important factor in ensuring that discharge took place in a safe and timely manner and in meeting patients' needs in a coordinated and holistic way.
- 6.3 Usual MDT attendees included Psychologists, Psychiatrists, Consultants, Ward Managers, Nursing staff, Occupational Therapists (OT), OT Assistants, Activity Workers, Clinical Leads, Discharge Liaison Managers, Senior House Officers, Physiotherapists, Patient Flow Coordinators, Social Workers, all of whom had a crucial role, and in linking into Social Work Hospital Discharge Teams.
- 6.4 Social Service Hospital Discharge Teams, specialist posts and dedicated 'community connector' teams were often (if not always) involved in MDT meetings, and would subsequently play a key role in linking in relevant community-based housing bodies.
- 6.5 Virtually all interviewees described the importance of and reliance on their existing network of services and resources during, but especially following discharge. Respondents described how Social Services, CMHTs, the Third Sector and especially organisations delivering services funded through the Housing Support Grant, play a huge role in meeting the physical health, mental health and ongoing wellbeing needs of patients once they are back in the community.
- 6.6 In terms of ensuring a patient's holistic care needs were captured and considered in a timely way the 'What Matters?' assessment/conversation was mentioned by some hospital-based staff as a document that addresses, amongst many things, the patient's housing situation. The use of this assessment was identified as a potential area of development for ward-based staff by one Head of Hospital Discharge.
- 6.7 It was felt that no one single measure could achieve the links needed to improve cooperation between services. Those described above reflect the role of individual staff expertise (and its availability), existing points of discussion about holistic care between professionals, patients and carers, and recognised tools for facilitating communication with patients about their needs are all of equal importance.



7. The key ingredients of successful partnerships

- 7.1 Funded through the UK Collaborative Centre for Housing Evidence's (CaCHE) Knowledge Exchange Fund our report 'Good Health Brought Home' sought to highlight the common features of successful partnerships between health, housing and social care.
- 7.2 The research looked at fifteen different projects from all over Wales, including those focused on reducing delays in returning home from hospital, lessening loneliness and isolation and providing specialist accommodation with support.
- 7.3 The report draws out six principles that underpin successful partnerships between the three sectors:
- A shared analysis of issues and solutions – providing the basis for partners to understand why change may be important and have a clear shared sense of how a solution can be achieved.
 - Person-centred services – reflecting on first hand experiences of people receiving services and utilising that insight to shape and design effective services and interventions
 - Leadership – the drive of staff (at all levels) to take forward solutions and forge new ways of working could not be emphasised enough
 - Joint budgets – given the risk associated with undertaking a partnership approach, the ability of each partner to commit any level of resource to secure a joint vested interest in the success of the work was considered important
 - Shared interpretation of legislation – cross-cutting legislation that each sector either must, or should act in line with (such as the Well-being of Future Generations Act) was often a positive driver to work together.
 - Recognition of power imbalance – with different partners coming with different levels of resource and power to effect change, effective projects would often recognise this in the interest of creating more cohesive ways of working together.
- 7.4 The report also reflects on activities that embed further joint working. This included the need to ensure sustainable long-term funding for well-evidenced projects; establish ways of holding joint-training and good practice sharing between professionals and sharing resources underpinned by a strategy where all patterns share a common interest in improving outcomes for people.

8. Actions to progress approaches both locally and nationally

A shared definition of housing advice

- 8.1 The Welsh Government should lead on ensuring that a definition of housing advice is more widely shared and disseminated among professionals and across disciplines, in order that it forms the basis for the assessment of housing needs with patients.
- 8.2 To support this, we believe the Welsh Government should develop practice guidance for all organisations involved in hospital discharge that shares



expertise and knowledge, and provides learning from good practice examples, with an emphasis on the role housing advice can play in facilitating effective hospital discharge.

Developing a protocol/procedure

- 8.3 Without a well-recognised hospital discharge protocol or procedure in place that is actively followed by hospital staff and which adopts a multi-disciplinary approach there is a challenge in ensuring how hospital and community-based services can work in the most effective way to meet patient needs during discharge.
- 8.4 Any protocol should include a focus on how the opportunity to identify housing needs and provide advice/support is prompted in a timely manner – and include how that initial discussion and subsequent plan capturing a patient’s housing needs is utilised at each point of engagement with professionals during the course of treatment.
- 8.5 Within this protocol there should be an effective notification or referral mechanism that health staff need to trigger when housing (and carer involvement) needs are identified, or where a lack of understanding of a patient’s housing situation may adversely affect their discharge.
- 8.6 The protocols should be actively monitored and reviewed, taking into account feedback from patients, carers and family members in addition to the wider spectrum of professionals involved to inform further refinement at a local level.

Coordinating the consistent input of housing expertise

- 8.7 Health Boards, relevant Housing bodies (Local Authority Housing Departments and Housing Associations) and other key partners (Social Services, Care Coordinators, ‘Community Connector’ teams) should review the assessment that is used when patients are admitted. This should include consideration of elements key to the quality of that assessment relating to housing advice including:
- A holistic consideration of people’s housing circumstances
 - The training needed to ensure staff feel confident in carrying out housing elements of the assessment
 - Agree a consistent approach to escalate the assessment if the information gathered initially is too vague to inform an approach to discharge planning
- 8.8 Area Planning Boards should take a lead in bringing all organisations involved in hospital discharge together to explore and develop solutions to address the wider social issues that patients may face.
- 8.9 Specifically focussing on carers needs - how Health Boards and Local Authorities can work together to identify or create the space for the Carers Assessment to be undertaken from ‘day one’ with carers, with housing need

forming a part of the assessment and supporting discharge planning arrangements.



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Consistent collaboration

- 8.10 We believe our ‘Good Health Brought Home’ research underpins the importance of having a consistent approach to partnership, drawing on what is more likely to produce success, longevity and impact for patients, carers and family members alike. We should not assume that partnerships are created or sustained easily and that both internal and external forces can compromise seemingly strong and well-established partnerships. There is a greater role for common principles, such as the ones outlined in our report, to play in supporting this collaboration – forming a consistent basis upon which to build success.

About CIH

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