Chartered Institute of Housing Cymru

From hospital to home; planning the discharge journey

C.A.R.P. Collaborations and Gana Consulting
Chartered Institute of Housing Cymru and Tyfu Tai Cymru

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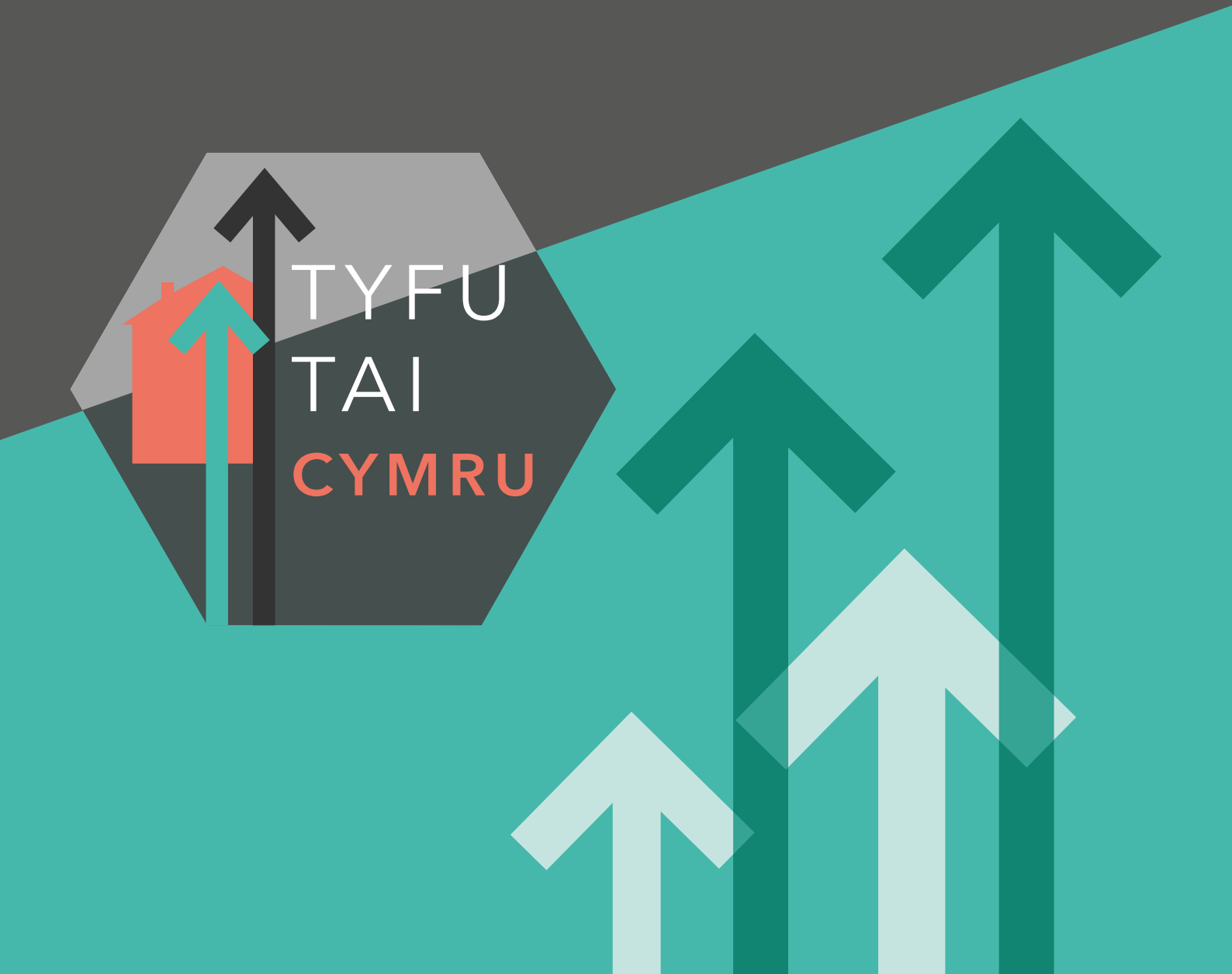

Background to the research

The commissioning of the research

Tyfu Tai Cymru (TTC) is a 5-year housing policy project currently in its fourth year, with a focus on providing insightful analysis and filling evidence gaps to support policy progression. Funded by the Oak Foundation the project is managed by the Chartered Institute of Housing Cymru and works across three key strands:

- Building the right homes to meet demand.
- Making sure housing is always a priority for local government.
- Demonstrating housing's role in keeping people well and healthy.

The rationale and aims of the research

The wide ranging research and project evaluation and sector specific strategic and operational experience that both C.A.R.P. Collaborations and Gana Consulting bring to the project has provided a clear perspective and understanding of the role of housing advice during the hospital discharge planning process. Equally both partners have brought a clear appreciation of the timely nature of this work in the context of the impact that the COVID-19 pandemic (since widespread lockdown across communities in Wales from March 2020) has had on the delivery of primary health care and other services, across Wales.

Set against that background, the commissioning of this work through the Tyfu Tai Cymru project has looked at exploring a number of key areas:

- Providing a contemporary analysis of when and how housing advice is used in the hospital discharge planning process.
- Providing a picture of how the COVID-19 pandemic has impacted/changed the hospital discharge process across the 7 Health Boards in Wales.
- Helping identify if there is variance in the role housing advice plays within the process comparing across Health Boards and providing an understanding of the reasons behind this.
- Including a focus (in the project work) on the experiences of people with protected characteristics and;
- Highlighting good practice that is taking place that sees housing advice, or better connections with the housing sector improve the effectiveness of the hospital discharge planning process.

Research preparation

The Literature Review

In preparation for our formal research interviews and survey we explored several literature sources, provided to us by the commissioner and by other contacts known to us as researchers, or identified by other professionals and organisations. We also took the opportunity to engage in a number of less formal investigative interviews with academics engaged in broader research work around hospital discharge.

The literature review provided us with a strategic overview of discharge at a national level and of the mixed and varied experiences of those engaged in discharge planning across Wales. It also provided examples of existing good practice, areas of delivery challenge and examples of improvement planning, engaging partners across health, social care and housing in the developing of a coordinated programme of hospital discharge at a local level.

This review was varied in nature and of particular note was the extensive set of strategic Wales Audit Office reports from 2017 for each Health Board area that looked at current arrangements in each location, the resources available and where areas for improvement could be made. A specific and detailed literature review exploring the scale, pattern and impact of Delayed Transfers of Care across Wales and the role of housing in addressing the issue and a Wales Audit Office report from 2020 exploring proposals to address the challenge in resource allocation and service delivery in meeting expanding and varied social care need across Wales [Wales Audit Office - '10 Opportunities for Resetting and Restarting the NHS Planned Care System" (2020)].

We also reviewed more specific documents and literature covering arrangements at a local level; the Vale of Glamorgan Council and Cardiff and Vale University Health Board (UHB) Delayed Transfer of Care (DTOC) Housing Procedures (as an example), and reviewing the documentation that has been drawn up and put in place by Health Boards across Wales to address service delivery (and discharge planning) in the face of the COVID-19 pandemic. The depth of content in this documentation illustrated the significant challenges placed upon the NHS in Wales in addressing both existing and emerging health needs and priorities as a result of the onset of the pandemic from March 2020.

Research findings

1. Defining housing advice

Prior to commencing our research, together with CIH Cymru we adopted the following definition that originated from Care and Repair Cymru for the term 'housing advice'. This was to ensure all potential participants would be starting from the same baseline of understanding of the term:

"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."

Interviewees were asked whether their understanding of the term housing advice differed in any way to the above definition. 52 out of 53 respondents agreed with the definition, in that it needs to be broad and consider more than bricks and mortar, and that many non-housing issues can impact on someone's ability to keep their home (only one respondent felt it only referred to actual housing).

2. The understanding and importance of the role of housing advice in discharge planning

All interviewees demonstrated or indicated that their roles included the provision of some level of housing advice to patients, even where they may not have occupied a professional housing role, or were not employed by a housing organisation. Three distinct professional groupings emerged:

- multi-disciplinary Social Work Hospital Discharge Teams, who play a fundamental role in discharge planning. All respondents interviewed demonstrated that their role(s) in these teams addressed all aspects contained within the housing advice definition.
- Local Authority Housing Options staff who have a statutory duty to provide advice and assistance under the Housing (Wales) Act 2015.
- nursing staff who either demonstrated very good housing knowledge, or others who relied on their well-established links and networks to ensure the most appropriate person was brought in to provide the right advice, and/or initiate the required housing related process or procedure.

There was no expectation from any of the non-health respondents that ward-based health staff should provide housing advice and equally that not all patients may require specific housing advice. However, there was an expectation 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.

Furthermore, among non-health staff interviewees there was an expectation that when housing advice was provided by health staff, it needed to be accurate and assist in managing (patient) expectations of available housing options.

3. Addressing hospital discharge

Health staff and Social Worker interviewees confirmed that most patients being discharged are not homeless or threatened with homelessness, and therefore most were not referred to their respective Local Authority's Housing Options Team.

Although no specific, consistent data on this could be sourced one Social Worker in Torfaen estimated that 99% of discharge patients on their caseload were not homeless or threatened with homelessness, with 60% of discharges involving adaptations and 80% requiring a variety of ongoing support once discharged.

Of the cases that are referred to Local Authority Housing Departments, respondents from 8 of the 11 LAs who participated stated that discharge cases relating to mental health were by far their most common challenge. Approximately half stated that they/or the Health Board had directly addressed the issue by investing in dedicated roles to assist and facilitate patient discharge from mental health units.

As an example, Caerphilly County Borough Council estimated that 90% of discharge cases they dealt with were mental health related and have introduced a funded post to manage and work with the referrals.

In contrast, City and County (CC) of Swansea estimated that 70% of their discharge cases were physical health rather than mental health related. One consideration here is that CC Swansea have not undergone the transfer of their housing stock and therefore discharges involving adaptations, which are predominantly if not entirely physical health related, still involve the Local Authority, or are directly dealt with by District Housing Offices.

Our 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. These teams or roles facilitated discharge by working to bridge the interface between hospitals and relevant community services and resources.

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.

These successes were achieved through long-standing working relationships, and/or where staff may have had prior working experience in a housing or other related setting. Whilst the need for additional staff/posts was mentioned in interviews (in the context of 'what could be better?'), an over reliance on individuals or single specialist posts was identified as having the potential to create challenges.

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.

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.

As an example, one interviewee indicated how hospital based staff 'have been lucky to have housing advice staff available from the local authorities we work with to provide this (service) for us'. In this case housing staff did 'more than just offer advice, as they (were) also able to make referrals and assist with applications'.

In one area it was identified that (non-specific) advice and support can be provided for home owners and support can be offered for general ongoing household bills and to address neighbourhood issues.

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.

4. Discharge planning

Although health professionals indicated that housing needs are identified as early in a patient's hospital stay as possible, there was an acknowledgement that housing needs were often not picked up soon enough after admission.

The use of protocols or procedures

The existence or use of a protocol or procedure was not regularly mentioned in our research interviews and where they were mentioned a number of 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, with 25% of respondents stating that having a protocol that was implemented, understood and followed was needed in the discharge process.

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.

Identifying patient need

Ward based staff highlighted that identifying wide ranging patient needs to inform the development of a comprehensive discharge plan often presented the following challenges:

- Unless the patient is known to ward staff, they can only go by what the patient says, which was described as 'not always true, accurate or comprehensive'. In interviews, some ward staff mentioned how family or carers can be helpful in providing information, but to what extent this takes place was not clear.
- Patients will sometimes say what they think nursing staff want to hear, with a view to being discharged as soon as possible. Therefore, their true housing need and situation may not always be known and can be difficult to establish. Again, the extent to which family or carers assist in establishing 'what matters' was not clear.
- 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. Advocacy services were mentioned by some respondents as a way of ensuring the patients' needs were duly considered, but to what extent this takes place, in addition to the involvement of family and carers was not clear.
- 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. The Local Authority who provided this as an example explained that because the assessed patient was not formally admitted, they subsequently were not formally discharged. It is not clear from such cases whether or not these are formally recorded as a 'discharge' under any specific protocol or agreement.

- Patients' needs change throughout their hospital stay. Amputees were mentioned by a number of respondents as presenting particularly complex case management issues, in respect of wound management, addressing physical health issues and addressing any needs associated with adapting the home lay out. Adapting a home to ensure it was wheelchair friendly was described as a serious challenge, one which was not always possible and a circumstance that occasionally resulted in alternative accommodation being required.
- Patients may discharge themselves prior to their needs being understood and discharge plans being in place, there being no obvious means to detain patients, unless under mental health legislation.
- 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.
- Some complex discharge cases were described by respondents as situations where:
    - The patients' accommodation is identified as being unfit for habitation, or;
    - The patients' needs change throughout their stay in hospital meaning their previous accommodation is no longer suitable, at all, or in its previous form.
- Interviewees cited several reasons in such situations relating to discharge:
    - Special equipment such as hoists being required which in turn requires adequate space to be operated safely and effectively;
    - Wheelchairs being required, which may have specific space requirements;
    - Accommodation with stairs no longer being suitable due to changes in patients' mobility;
    - 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 psychosocial needs.
- Interview respondents also explained that accommodation can sometimes be adapted to meet the required needs, but this can be timely and costly meaning grants first have to be accessed. However, it was also noted that even when new accommodation is required, it can still need adaptation. Bariatric cases were given as specific examples where new doorways need to be built to enable movement throughout the property, which in itself often presented significant technical challenges.

Discharge planning in practice

Although in interviews most health professionals indicated that housing needs are identified as early in a patient's hospital stay as possible, from our research it was apparent that the actual timing of discharge planning, as an overall process presented a mixed picture.

It was apparent that the process of identifying housing needs can be separate from the process of using that information to plan discharge.

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.

Planning varied widely from hospital to hospital. In some cases starting on or just after admission, in other cases taking place a couple of weeks prior to discharge, or even as late as when the patient is deemed clinically optimised/discharge ready/medically fit. Our interviews indicated that hospitals also used different terms to 'describe' when a patient is ready for discharge.

The different hospital based 'fora' used for discussing and planning discharge also varied, including ward rounds, ward-based reviews, patient flow meetings, discharge planning meetings, and MDTs.

Having a rapid allocation system or process for referrals that is informed by the collaborative expertise of professionals and organisations could assist in formulating timely and accurate discharge plans that holistically address patient needs.

The importance of a multi-disciplinary approach in discharge planning

Our research indicated that a multi-disciplinary 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.

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.

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.

However, some community-based services, such as Adult Services Teams and Community Mental Health Teams (CMHTs), and the majority of Registered Social Landlords (RSLs) and Housing Options staff, voiced some criticism that they were only occasionally invited to MDT meetings. They all added that they were ready and willing to engage, and that their earlier involvement would be of significant benefit in supporting timely and effective hospital discharge.

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As an example, one service manager for a CMHT explained that her team were Care Coordinators, and that their involvement in discharge planning was essential. However, she added that sometimes they only hear about a discharge after it had happened.

As positive examples of multi-disciplinary/ agency working, interviewees cited posts that were jointly funded between Local Authority and Health, in which a specific professional was either employed by health or housing.

Although beneficial in terms of an integrated approach to addressing discharge, some concerns were also noted in relation to conflicting organisational priorities, frameworks and guidance in such settings.

However, being based in a hospital setting enables staff with housing expertise to work collaboratively with health staff in an effective way. In a setting where that happens staff frequently take on the role of linking in housing bodies and other community-based services.

Information sharing

From our research it is clear that some services were well integrated with shared IT systems, paperwork, and assessments offering equity and ease of access to patient records across disciplines and directorates.

Despite respondents describing the benefits of being able to access other departments IT systems/records for the purpose of sharing patient information, the inconvenience of having to use multiple IT systems was highlighted. This was particularly the case where health and social services departments may use different patient/client databases and this presented problems for staff in accessing and sharing accurate and up to date information relating to patients in a multi-disciplinary setting.

5. Ensuring suitable arrangements are in place in the home

Interviewees indicated the challenges organisations faced in ensuring that they receive early notification in planning discharge if a house is not a suitable environment for a patient to return to, or for carers to be able to provide post-discharge support to patients.

In one hospital setting interviewees reported referring an increasing number of patients for a 'clean and clear' of the patient's home property (before discharge happens); where the condition of the home the patient is returning to may be a cause for concern.

This was perceived as a benefit as this task was led by a professional, providing an objective assessment of the condition of a property, rather than being based solely on the patient's views, or recollections. It was noted that

'generally such cases are discharged within weeks' but could on occasion cause discharge to be delayed for 6-12 months.

This could be where the patient may have more complex health needs, or the property is not deemed to be suitable for a discharge, where there may be a lack of a suitable property or where owning a home may be a barrier to adaptations being carried out with regard to how they are paid for.

One interviewee cited examples where 'hospital stays of longer than 14 days are usually not due to housing issues'; meaning that the delay was more linked to the patient's health condition or a waiting period for physical changes to the property being undertaken (as opposed to accommodation not being available).

This however poses questions of whether in such circumstances the patient is 'medically fit' for discharge, and how the need for adaptations may be viewed in a health setting, if it is not consistently viewed as a housing issue (we would argue that the need for accommodation being suitable is clearly a 'housing issue').

Some interviewees working in community-based services described their concerns when accessing a recently discharged patient's home, only to find it unsafe for habitation. In such situations OT assessments could be undertaken in a timely manner and Housing Associations could act (more) quickly if adaptations are required.

Equally hospitals could avoid discharging patients in the evening (for example to a cold house, or where neighbours are the only support available) and allow patients to stay in hospital until a more appropriate discharge time could be agreed.

Such examples highlight the challenges staff face during the discharge planning process, where the actual accommodation situation may not be disclosed by the patient, or where they may describe it differently to the reality of the situation (linked to a not unnatural desire to want to return home).

6. The timing and involvement of other organisations in discharge planning

Of the discharge cases that are referred to Local Authority Housing Departments, 19 of the 22 respondents working in housing services said that they were either occasionally or frequently involved far too late in the discharge planning process.

Of the 7 Housing Associations that took part in the interviews 5 stated they were involved too late, or even, not at all, with their tenant's hospital discharge planning. Another was not able to comment due to the (unspecified) nature of their role and service, and another provided a floating support worker who was allocated to support the Social Services Hospital Discharge Team, to address housing related issues.

One interviewee indicated that there needed to be an understanding that discharge can be complex and operate on 'different levels' and that 'one size doesn't fit all' as a solution to ensuring discharge works smoothly.

A common view shared by interviewees was that organisations need to work together to develop different pathways that reflect, accommodate and plan for differing levels of complexity, both in relation to the health needs of patients, but also taking full account of their housing situation and the social factors that may impact on their general wellbeing and the suitability and sustainability of accommodation.

These may take the form of addressing longer term mental health and wellbeing needs and the need to address people feeling safe at home, or tackling social isolation and loneliness.

At a strategic level interviewees raised the need for all partners to engage in a Delayed Transfers of Care (where discharge may be delayed for a number of reasons) conversation, and in establishing the role housing plays in addressing that issue. Interviewees indicated that it is equally important to establish clear pathways and mutual understanding across differing organisational disciplines and functions.

However, by contrast where constructive joint planning and co-ordinated working has led to the creation and funding of dedicated teams and posts to improve hospital discharge, Local Authority staff in Cardiff and the Vale of Glamorgan reported not seeing significant issues with addressing discharge planning.

Equally in Torfaen staff from the housing team reported that joint working has facilitated them being invited to relevant discharge planning meetings, and that they also operate a Social Care and Housing Complex Case panel that meets monthly.

Having staff with housing expertise employed by health services and working to an integrated model, in the majority of discharges cases, can lead to the right housing advice being provided and to housing providers being engaged and involved at the 'end point' of discharge planning (through the provision of accommodation) in a timely manner.

7. Meeting the communication needs of patients during discharge planning

The experience of a planned or unplanned hospital stay can be a traumatic one for many people and the need to ensure that the voice of the patient is heard consistently and that their needs are taken into due consideration in discharge planning is of paramount importance, if discharge back home is to work effectively. In support of this all professionals need to be sensitive in engaging in discussions around personal matters (whether they relate to health, housing or social needs) these should be conducted in private, taking due account of each patients' communication needs and requirements.

In our research all interviewees described offering a personalised approach that drew on various tools and resources, such as language line, local interpreters, speech and language therapists, sense, signing touch, sign boards, hearing amplifiers and large print to ensure patients understood what was being communicated to them.

Social Services professionals saw it as being integral to their role to ensure that their patients/clients understood what was being said to them, and that they were able to effectively advocate on their behalf.

There were no particular procedures mentioned with regard to establishing whether communication with patients took place in a consistent manner, but interview responses indicated that the general approach was personalised and needs led.

From a patient and carer perspective survey feedback indicated that staff involved in discharge planning do not consistently communicate or have conversations with family/carers to establish what a carer is willing and (importantly) able to do.

Ensuring that this happens is of particular importance where patients may be reliant on the help and assistance of family and carers in the practicalities of discharge (for example, transporting the patient home, making sure that the home environment is suitable for a return, or following up on some of the aftercare arrangements that may be required).

Interviewees indicated it would be beneficial that family and carers were identified early on and were involved in discharge planning conversations at an early stage and if discussions around discharge planning did not take place in a public setting such as in 'front of the entire ward'.

Interviewees indicated it would be beneficial if professionals can ensure that discharge arrangements are communicated in clear simple terms, to avoid misinterpretation or misunderstanding taking place, particularly where patients, family and carers may not be conversant with clinical language, definitions or descriptors.

8. Discharge outcomes and meeting patients' needs following discharge

Advance notice to ward staff or the Local Authority where a patient will be homeless on discharge and a prompt referral to a Homelessness Prevention Officer in cases where the "what matters" assessment identifies a possible housing need can be critical in ensuring that the outcome from a hospital discharge is a positive one.

However, even where a Homelessness Prevention Officer is based at a hospital and may spend time introducing themselves to ward staff, our research found examples where it is not unusual for the housing aspect of the "what matters" referral to not be prioritised and that patients can be discharged who are not known to the Council's Homelessness Team.

- 31 out of 52 interviewees confirmed that they had had concerns regarding patients being discharged to unsafe/insecure environments, with a further 2 respondents stating that the environment was not necessarily unsafe but was unsuitable.

- Of the 31 interviewees, 16 respondents (mainly housing bodies) gave late notification/involvement as the primary cause for discharge being unsafe, 9 respondents (mainly from health and social care) gave the reason that patients with capacity had the right to make their own decisions, but some of those decisions were not always considered to be in their best interest.
- The remaining 7 interviewees gave reasons such as (an over) reliance on patient information which was not always true or accurate, and which resulted in unmet needs.

The most common reasons for respondents saying discharge was unsafe were:

- Patient discharge into temporary accommodation that was not suitable for a patient's needs. This is of particular relevance for patients with a mental health condition being discharged into bed and breakfast or hostel accommodation, where other residents with substance misuse issues or offending behaviour presented an unsuitable environment.
- Patients returning to properties that were not deemed safe or habitable, normally in circumstances where the patient wanted to return home.
- Patients being discharged back to properties where the required arrangements in relation to equipment (to assist with addressing a physical health need), care packages or adaptations had not been put in place/carried out.
- Patients being discharged back to properties that were no longer suitable to their needs, for example, to a two-storey house where the patient was no longer able to climb stairs.

Interview responses indicated that the involvement of Social Services in discharge planning resulted in far fewer patients being discharged into unsafe or insecure accommodation settings.

However, it was not uncommon to find that housing departments and housing providers would refuse to accept a patient being discharged; explaining they had not been given sufficient time to prepare and the discharge would be unsafe. In some cases cited by interviewees, ambulance crews returned the patient back to hospital.

Many interviewees stated that hospital re-admission was far more likely in cases where the discharge was rushed or poorly planned, and without the relevant people being involved.

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.

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9. The impact of COVID-19 on hospital discharge

Prior to the COVID-19 pandemic, some Local Authority Housing Options services described problems with patients being discharged from hospital and sent to present as homeless. With offices being closed to the public, ward staff have had to 'phone ahead prior to discharging patients, which was welcomed by housing staff.

As a result of Welsh Government's temporary removal of the priority need condition (as an eligibility criteria for statutory assistance), and all rough sleepers being offered accommodation, a common theme from Local Authority Housing Departments was that all their temporary, and supported accommodation was full, and that their bed and breakfast use had increased. This had resulted in 'bed blocking' (or Delayed Transfers of Care) in hospital settings and a loss of choice in where to place people, following hospital discharge, or how their accommodation needs were to be met.

Some respondents, in both hospital and Local Authority settings described how some 'red tape' and bureaucracy had been eliminated during the pandemic (through specific COVID-19 measures being put in place) resulting in simpler and more efficient working.

Despite a considerable number of meetings being hosted through online video calls, which some interviewees described as easier to arrange and attend, comment was also made on how the lack of face-to-face work with patients/clients/colleagues was less effective at fully understanding patients'/clients' needs, or in building rapport or in having productive conversations.

Some staff in specialist roles that had previously spent the majority of their time working on hospital wards (and who were then told they couldn't attend, due to COVID-19 restrictions), faced difficulties in having to rely on non-specialist colleagues relaying their views, feedback or assessment in discharge cases.

The experiences of working through the pandemic offer the opportunity for organisations to learn and develop together and to implement working practices that promote and inform system change in discharge planning by streamlining processes and reducing 'red tape'.

10. Hospital discharge - the patient and carer perspective

From the small number of interviews we undertook 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.'

Even though the Social Services and Well-being (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. 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.

Our interviewees indicated that the COVID-19 pandemic led to further complications regarding discharge with a lack of Personal Protective Equipment (PPE) compromising how safely care workers could work in the patient's home environment, post-discharge. Anecdotal feedback from a number of carers (involved with organisations at a national level) highlighted the concern that families had about vulnerable patients being discharged home in these circumstances.

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.

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.

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.

A firm belief was expressed that a carer's assessment is key to ensuring that discharge planning works well and reflects the needs of patients, families and carers (the latter two often 'performing' the same role) and that addressing housing need by providing appropriate advice and planning could sit at the heart of that. However, it was noted that there is no specific duty on health services to undertake a carer's assessment, in current legislation.

As was indicated to us by one interviewee, 'there is a carrot, but no stick'; the legislation needs strengthening.

Research findings - the online questionnaire

We received 17 responses to the Survey Monkey questionnaire, providing us with a snapshot, with respondents coming mainly from the Aneurin Bevan University Health Board area, with others from the Cardiff and the Vale, Hywel Dda and Betsi Cadwaladr Health Board areas.

What patients and carers told us

Overall

- **64%** of those responding had been directly involved in hospital discharge arrangements, with **50%** reporting a status as a former patient
- **84%** reported that their hospitalisation was due to a physical health need
- **56%** of respondents were owner occupiers, with **22%** holding a tenancy either with a Local Authority or RSL, whilst only **6%** reported that they had been homeless on admittance to hospital
- The length of hospital stay varied from **50%** of respondents staying for less than 1 month, with **28%** staying in hospital for less than 3 months

About discharge planning

- **62%** of respondents reported being asked about their housing needs/housing situation, with health staff (74%) being the lead professional engaged in those patient conversations
- **65%** reported that they were only asked about their situation at the end of their hospital stay and only **15%** reported that these questions were asked at the start or during their time on a hospital ward
- Only **33%** of those responding reported that they fully understood how discharge planning worked and that their needs were considered, with 38% reporting that this was partially the case. However, **27%** of respondents felt that they didn't understand the process/that their needs had not been considered in discharge planning
- **39%** of respondents felt they were either 'very or reasonably well informed and involved' in the discharge planning process, with **56%** feeling that they were only 'a little informed or involved'

- Of those who were contacted in relation to a discharge taking place, **68%** of those were either partners, or family and friends, with **23%** being the Local Authority Housing Department/a support worker, or other professional.
- **75%** of respondents reported that they were not offered information relating to discharge in a range of formats, such as a range of languages, or in an easy read document. This raises questions about how information is consistently disseminated (one Health Board has a website link to a patient information leaflet on hospital discharge, but the provision of such public information was unique).

About discharge outcomes and meeting patients' needs post-discharge

- Reflecting on personal circumstances post-hospital discharge, **50%** of respondents felt that the arrangements put in place for their discharge were 'OK', with 34% rating the arrangements made for them as either very good, or good.
- There was an equal **50:50** split in respondents feeling they had been listened to or not listened to when their discharge was being planned.
- **56%** of respondents reported there being no change in their housing situation post-hospital discharge, although it was not possible to determine the reasons that may lay behind this.
- The impact of COVID-19 on hospital discharge does not appear to have been a significant issue, with **56%** of survey respondents reporting that it had no effect upon their discharge arrangements.

Recommendations from our research

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. They should consider:

- The multiplicity of language and terminology used to both describe the discharge process and to identify professionals involved in discharge. It would be beneficial if a communality of understanding could be developed to ensure that misinterpretation around professional roles or discharge arrangements does not occur, or negatively impact on successful discharge taking place. The use of a clear set of terms, definitions, or descriptors (such as the housing advice definition) could be a useful aid in this.
- We would also note the value of establishing clarity of definition, as a tool to reinforce the importance that housing plays in the discharge process

2. 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, and:

- Identify and confirm the importance that housing plays in effective discharge planning
- Adopt a clear understanding of the language being used relating to housing, resulting from recommendation 1
- Confirm what is housing related within the assessment
- Ensure it covers all aspects of a patient's housing situation
- Ensure it addresses the needs and capabilities of carers when they are or could be involved
- Agree how to approach or escalate the assessment when patients are vague, or possibly not being accurate in describing their housing situation
- Confirm essential information that health staff need to be aware of regarding housing issues relating to discharge; specifically information that assists housing bodies in managing expectations regarding housing options
- Identify whether the (re)allocation of staffing resources at the stage of (housing) assessment, could offset additional time and resources being expended later in the discharge process, or when a patient may be re-admitted to hospital
- Identify the training or resources required to ensure health staff are competent in carrying out the housing aspect of the assessment

3. Health Boards, relevant housing bodies and other key partners should review when and how the above assessment is carried out and used, and:

- Consider the timing of the assessment
- Consider the consistency of conducting the assessment with different staff, wards and hospitals
- Confirm the best approach to how the housing aspect of the assessment is updated to reflect the changing health needs of the patient
- Identify who is best placed to provide the right housing advice when it is required, considering the various case studies (and other options) provided within the Appendices
- Establish 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
- Confirm how to decide when the optimum time for discharge planning is to be initiated for each patient (reflecting on the challenges identified within the process outlined in this report)
- Agree how the patient's housing related needs are then considered within the discharge planning process
- Confirm how those relevant housing bodies/experts are then consistently involved within the discharge planning process to ensure the best housing advice is provided
- Establish how carers are brought in and involved in the discharge planning process.
- Identify how those relevant housing bodies/experts are updated in line if/when the health needs of a patient may change
- Agree how to identify the most appropriate known point of contact within wards/ hospitals for community based staff that facilitates effective and efficient communication relating to discharge

4. Health Boards, relevant housing bodies and other key partners should review whether the integration of services involved in hospital discharge is beneficial and possible, and consider:

- How to overcome conflicting priorities, policies and frameworks
- How information can be shared most efficiently and effectively
- Whether joint funding services/posts is viable and beneficial
- Whether the sharing of multiple or a single IT resource is possible
- Developing an automated referral/ notification mechanism to housing bodies and care coordinators upon housing needs being identified

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5. Health Boards should review the impact of how the pressures and priorities placed on ward staff to free up hospital beds can lead to rushed and poorly planned discharges, giving consideration to:

- Ensuring the (wider) causal factors of admission have been resolved
- The negative impact on the patient, if discharge is not addressed adequately
- The negative impact on family and carers,
- The potentially avoidable costs, to the NHS/Health Board associated with re-admission to hospital

6. Health Boards and Local Authority Housing departments should review the following:

- How the housing needs of people entering mental health units for assessment (possibly for hours/days), who are not formally admitted to hospital (due to not meeting treatment criteria) and who then consequently have an immediate housing need, can still be effectively met
- How professionals may assume or expect families/carers are able to fill the gap in coordinating or fulfilling the (housing) arrangements for patients in the discharge process
- 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. Better use could be made of Carers organisations and the resources and expertise they have to support this work taking place. Their involvement could support and promote greater awareness among health staff of the roles of family/carers in supporting vulnerable individuals.

7. Health boards should review how expert staff with housing knowledge and information can remain linked-in and accessible to patients, family members, carers and health professionals in the current COVID-19 climate, where involvement in meetings and face to face interactions remains limited.

This would ensure that clarity of communication is maintained, and that changing patient needs or the availability of housing options are relayed in a timely fashion to each person or organisation engaged in discharge planning.

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. Loneliness, isolation and maintaining positive mental wellbeing should be reflected and addressed in discharge planning.

There is a clear need to adopt a multi-agency approach to identify, plan and address these issues, which have the potential to impact upon a successful discharge taking place. It is clear from our research that social issues may not be the responsibility of any one organisation, but that a failure to address them can lead to a DTOC, or unsafe discharge occurring.

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relevant Housing bodies and other key partners should:

- Review and update / develop new hospital discharge protocols that ensure the details and requirements relating to patient needs are shared in a timely manner with professionals working in community based services, with a view to 'getting things right the first time'
- Establish a bi-annual review of the protocol's implementation, providing an opportunity for key bodies and individuals to keep talking, and ensure consistency of application, identification of barriers and solutions, and ensure that the protocol continues to underpin effective hospital discharge

the following:

- Developing and enhancing practice guidance to all organisations involved in hospital discharge that shares expertise and knowledge, and provides learning from good practice examples. It is vitally important to ensure that all partners are working towards the same goal and have a clear understanding of the remit and limitations of their roles
- From our research it is apparent that Health Boards and Local Authorities across Wales have approached hospital discharge in different ways, but have identified areas of good practice, which could be used to address similar challenges professionals may face in other geographical areas. This presents a clear opportunity for professionals across sector and discipline to share the learning and successes of colleagues across Wales.
- During the pandemic it is clear that some hospitals and Local Authorities responded to the challenge in ways that saw processes streamlined, 'red tape' removed, and which ultimately improved their ways of working. Such gains should not be lost, and this work offers Welsh Government the opportunity to share and promote learning from those experiences, using it as a driver to inform broader system and service delivery change
- Welsh Government should undertake an urgent analysis of the temporary accommodation available for local authorities to utilise in discharge planning and delivery. This should include due consideration of the standard and quality of this accommodation to ensure its use to support hospital discharge is appropriate and makes best use of resources.

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Research delivery

About C.A.R.P. Collaborations and Gana Consulting

Since 2013, C.A.R.P. has delivered over 30 research and evaluation projects commissioned by organisations as varied as the Welsh Government, Health Boards and statutory and voluntary sector agencies across Wales.

This portfolio of projects has involved designing and delivering research, scoping, gathering, interpreting and reporting complex information and the ethics of conducting social research with vulnerable people, identifying good practice and undertaking comparative analysis of projects. Our aim in delivering our work is to provide innovative solutions and recommendations that can aid policy development and inform legislative and practical change.

Created in August 2020, Gana Consulting provides an independent expert consultancy service, backed by extensive experience of the homelessness and supported housing sector, providing commissioners with high quality strategic and operational advice, solutions and support.

Our joint experience is drawn from C.A.R.P./ Gana project work and from previous employment in strategic management within homelessness, advice and mental health services and in senior management developing and managing a range of services including; outreach, residential, substance misuse, young people, hostel, temporary, family, dispersed, floating support, learning and development, bond boards, and advice/ drop-in services.

Our partnership approach for this project combines considerable experience and understanding in the practical application of qualitative research methodology, including combining qualitative and quantitative approaches in order to fully explore research questions.

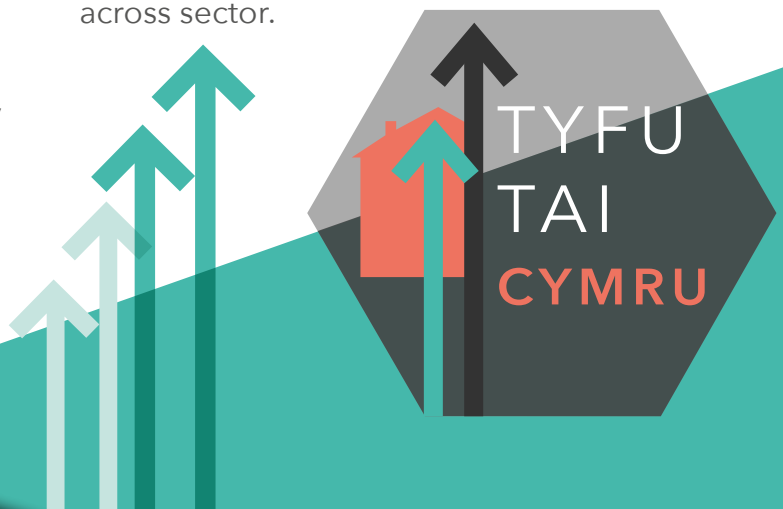
Our approach

As in all of our project work we used creative and flexible methods, designed to be sensitive to the needs of all audiences, to enable professionals and individual participants to fully engage in the process of scoping, researching and gathering information.

In addition, we worked to ensure that we were able to draw on both the wide network of contacts available through CIH Cymru at strategic and operational levels, as well making best use of our own networks, developed through current and previous work experience across the housing, homelessness, social care, health and third sectors in Wales.

Our methodology

With varying degrees of success we adopted a mixed 5-strand methodology, that was designed to take account of COVID-19 restrictions, to elicit the widest range of responses possible from potential participants, and which would allow us to gather a wide range of data and information across sector.



1. Review

We undertook a literature and policy review, as well gathering and analysing existing secondary data held by CIH Cymru and other organisations.

2. Conducting virtual face to face and group interviews

We started with developing a clear definition of housing advice, to use a benchmark, or baseline against which to set our questions and to ensure that there was a common understanding across sector and professionals in differing disciplines of the role and function of housing advice in the hospital discharge process.

We then developed a set of research questions for three groups; health and social care staff, housing professionals and patients and carers (these are provided in the Appendices at the end of the report), with each interview designed to last 20-30 minutes, either through Zoom/similar online tools, or through a telephone interview.

We took into account the time pressure for professionals to be able to commit to interviews (although in practice interview timings varied considerably) and retained the flexibility for interviews to be conducted in a group setting with a number of team members (as happened on a number of occasions). Due to time constraints some professionals took the opportunity to provide written responses to the virtual face to face interview questions.

The question set was also flexible enough to be adopted for use between strategic, managerial and operational roles, across organisation and sector.

3. On-line questionnaires

We developed a set of questionnaires using the Survey Monkey online tool, again for health and social care staff, housing professionals and patients and carers, with each survey designed to take up a maximum of 15 minutes for participants to complete (again appreciating the time pressures that professionals may be faced with in engaging in more detailed face to face interviews). We also offered participants the option of follow up interviews.

4. In person virtual patient questionnaires

We explored the option of conducting virtual interviews with patient groups/ individual patients and the use of a hard copy questionnaire that would have been mailed to/be available in a number of health or housing settings, with a return envelope.

Unfortunately the COVID-19 logistical requirement to reduce the use of paper based products (that could potentially be handled by a number of people), meant that it was not possible to follow up on this option. We were, however, able to offer patients, carers/ organisations the opportunity to take part in follow up interviews.

5. On-line hosting

We also explored the option with professionals/organisations across the statutory and voluntary sectors to host a GDPR compliant questionnaire link on websites, or on various social media platforms, or in online or hard copy staff newsletters, circulated as a part of organisational communications strategies.

However, for COVID-19 restriction and logistical reasons we were not able to undertake this as widely as we anticipated, although we remain grateful to the organisations and individuals, who 'advertised' and promoted the project and its' work through their own professional networks.

6. Acknowledgments

Greg Thomas (C.A.R.P.) and Antony Kendall (Gana) would like to acknowledge the support we received from the Tyfu Tai and CIH Cymru team in both the research and the development of this report. We would also like to give thanks to all of the project participants across Wales who gave of their time freely. We are very appreciative of their input and respectful of the work many people do in supporting hospital discharge.

Limitations and barriers

The project ran from January 2021, through to mid-May 2021 (the project was extended with the consent of the commissioner to take account of the Senedd elections).

There were challenges in ensuring consistent, detailed engagement with health professionals, although staff from 5 out of 7 Health Boards did respond to interview requests and requests to complete the online questionnaire. But, given the impact of COVID-19 on health resources, this was not unexpected and we make this observation without any implied criticism.

We identified organisations across Health, Social Services, Housing Services (including Housing Options teams), The Third Sector, and Housing Associations and we contacted 154 individuals across Wales. From those contacted, 53 people took part in the research interviews (with another 17 people taking part in the Survey Monkey online questionnaire).

The response from both Health and Social Care and housing professionals was minimal through the Survey Monkey tool, but this was offset by the numbers of virtual group and individual interviews we were able to undertake during the course of the project.

Input from all participants provided invaluable insights into discharge planning perspective and we remain grateful to the staff who gave their time for interviews and the completion of the online survey.

Working with patients and carers

Uptake for interviews was low, although this was offset by engagement in the Survey Monkey online tool. The reasons behind this appear to centre on reaching and being able to interview patients, or former patients, given the constraints of the COVID-19 pandemic and the accessibility of such interviewees in a hospital setting.

Equally, the often indeterminate length of a hospital inpatient stay and nature of discharge planning largely dictated that it was difficult to access patients for interview purposes even by contacting hospitals directly (by telephone), or by requesting onward referral and engagement (in line with patient confidentiality and GDPR regulations) from professionals engaged in discharge planning work. The sharing of paper questionnaires was not possible due to COVID-19 restrictions.

In addition to the pandemic related challenges we faced in reaching and engaging with patients we also faced a challenge in navigating the front desk contact/ reception facilities in hospitals, but are grateful for the support other professionals and also carers and patient groups offered in directing us to patients, or in disseminating the work of the project.

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The number of interviews with carers and representatives was small, again for reasons of reach and accessibility, although there was more success in attracting patients, carers and representatives to the Survey Monkey survey.

Sourcing data

1. Considering the research topic, the number of respondents from Health was lower than we anticipated.
2. Participation with Local Authority Housing Departments (Housing Options and Allocations) was secured in 11 of the 22 Local Authorities. However, the small proportion of hospital discharges that are referred to housing departments means their contribution is only directly relevant to a small percentage of all hospital discharge cases.
3. Area Planning Boards were approached with regard to what data they held regarding hospital discharge, but only two responded. Anecdotal information was provided, but no data was available for us to take into consideration.
4. Although we have been able to develop a picture of the situation across Wales in relation to hospital discharge, we would note that the picture is not entirely complete.

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Tyfu Tai Cymru -
"From hospital to home;
planning the discharge journey"