HDP09
Ymchwiliad i brosesau ryddhau o'r ysbyty
Inquiry into hospital discharge processes
Ymateb gan Unigolyn
Response from an Individual

Hi,

I've tried to be as constructive as I can and I'm sorry if this goes beyond your remit. I'm a social worker in an Older Person's Team and have a 7 years experience in my statutory role which has included extensive hospital discharge experience. I hope that this is helpful.

*A limited number of smaller community rehabilitation/assessment beds. For example, we have two in Caerphilly which has a total capacity for 14 people. Often these are used successfully as a step-up or step-down facility. This can result in delayed transfers of care, particularly if a person presents with a level of need that is potentially higher than their baseline but does not warrant an acute bed.

*I'm not entirely sure whether the social work role is fully understood by some colleagues in health. Occasionally I think that the social work assessment is seen as an administrative function to process people out of hospital. This of course isn't the case but can occasionally prove time-intensive to manage expectations as a result. On the contrary, the social work role offers balance to a predominantly medical model and is a really important function as part of a safe hospital discharge.

*Communication is difficult at our hospital sites. This is consistent with feedback from families/carers that I have worked with over the years. It is simply too difficult to speak to somebody responsible for caring for a loved one. This can also cause delay from a discharge perspective, often resulting in an unnecessary journey to the hospital site to review a person's needs.

*The availability of nursing home vacancies. This can prove particularly problematic in a private market. This might cross-reference with the point above, but nursing home vacancies are increasingly difficult to commission with occasionally placement's being sought far out of county which people can understandably be reluctant to agree to despite the choice policy. This also applies to nursing respite, although is not within the remit of this consultation.

*Disputes regarding funding. This will obviously pre-date CV19, but does also apply now despite the new streamlined guidelines. Pre-CV19, funding disputes between the LHB and LA were particularly time-intensive. The discharge to assess model used currently as a result of CV19 has been broadly welcomed across the board in my view, although is still used too selectively. These are now more recently being accompanied by trigger meetings to discuss eligibility for discharge to assess, which can result in unnecessary delay.

*In the current climate, social work staff are predominantly gathering information remotely. This is partly because of the prevalence of CV19 both locally and at our hospital sites. I understand that the gathering of information remotely can prove time consuming for ward staff, however often this is not a priority for our health colleagues

and pressure is applied to social work staff to visit wards instead which they are not permitted to do. As a result, information is being gathered hurriedly or inaccurately which can cause delay. Designated hospital discharge assistant's have in the past been effective communicators and work well across the two authorities (LHB and LA).

*As well as hospital discharge, it may be appropriate to widen the scope of the consultation to include inappropriate hospital admission. From my own experience, typically this is the result of a failure of primary care (whether that's GP, community nurses or particularly the community mental health team). It will obviously also include the inadequate resourcing of the social care sector which can occasionally also be a reason.

*Finally, the inadequate resourcing of the social care sector. This is a national problem and the current model simply isn't fit for purpose. All too often capacity is stretched or non-existent, the quality of care is poor and the wages offered are even worse. The standard of care is better when the appropriate training, supervision, employment benefits and salary is better. I feel quite strongly that domiciliary care staff have been nothing short of heroic during the public health crisis and their employment terms do not reflect this. We should be driving up standards, investing money to free up capacity and paying staff a better wage (per hour worked as opposed to per call that does not include journey times).

Thanks,