Agenda – Local Government and Housing Committee

Meeting Venue:

Committee Room 5, Tŷ Hywel

Meeting date: 3 April 2025

Meeting time: 09.15

For further information contact:

Manon George

Committee Clerk

0300 200 6565

SeneddHousing@senedd.wales

Hybrid

Private pre-meeting

09.00 – 09.15

1 Introductions, apologies, substitutions and declarations of interest

09.15

2 The role of local authorities in supporting hospital discharges: Evidence session 4

09.15 – 10.05 (Pages 1 – 42)

Faye Patton, Policy and Project Manager, Care and Repair Cymru

Alicja Zalesinska, Chief Executive, Tai Pawb

Johanna Davies, Head of Health and Social Care, Wales Council for Voluntary Action

Attached Documents:

Research brief

Paper 1: The role of local authorities in supporting hospital discharges – written evidence from care and repair Cymru

Paper 2: The role of local authorities in supporting hospital discharges – written evidence from Tai Pawb

Paper 3: The role of local authorities in supporting hospital discharges – written evidence from the Wales Council for Voluntary Action (WCVA)

Break

10.05 - 10.10

3 The role of local authorities in supporting hospital discharges: Evidence session 5

10.10 - 11.10 (Pages 43 - 59)

Melanie Minty, Policy Advisor, Care Forum Wales
Sanjiv Joshi, Treasurer, Care Forum Wales
Professor Samantha Baron, National Director, British Association of Social Workers

Attached Documents:
Paper 4: The role of local authorities in supporting hospital discharges – written evidence from Care Forum Wales
Paper 5: The role of local authorities in supporting hospital discharges – written evidence from the British Association of Social Workers (BASW)

Break

11.10 - 11.20

4 The role of local authorities in supporting hospital discharges: Evidence session 6

11.20 - 12.10 (Pages 60 - 69)

Rob Simkins, Head of Policy and Public Affairs, Carers Wales
Kate Cubbage, Director, Carers Trust Wales

Attached Documents:
Paper 6: The role of local authorities in supporting hospital discharges – written evidence from Carers Wales
Paper 7: The role of local authorities in supporting hospital discharges – written evidence from Carers Trust Wales

5 Papers to note

12.10

5.1 Housing support for vulnerable people

(Page 70)

Attached Documents:

Paper 8: Housing support for vulnerable people – additional information from the Welsh Local Government Association

6 Motion under Standing Order 17.42 (ix) to resolve to exclude the public from the remainder of this meeting

12.10

Private meeting

12.10 – 12.35

7 The role of local authorities in supporting hospital discharges: Consideration of evidence

12.10 – 12.25

8 Forward work programme update

12.25 – 12.35 (Pages 71 – 73)

Attached Documents:

Paper 9: Forward work programme update

Agenda Item 2

Document is Restricted

02920 107580
enquiries@careandrepair.org.uk
www.careandrepair.org.uk

Care & Repair Cymru
Mariners House, East Moors Road
Cardiff CF24 5TD

Care & Repair Cymru

The Role of Local Authorities in Supporting Hospital Discharge

Care & Repair Cymru

Care & Repair improves homes to change lives. We help our clients to live independently in warm, safe, accessible homes by delivering housing adaptations and home improvements. We offer a holistic casework service including a whole house assessment taken from a national framework, including a falls risk assessment, welfare benefits check and home safety information and advice. Our Hospital to a Healthier Home service helps speed up safe hospital discharge and reduce readmissions. Our specialist caseworkers work with hospital staff and patients to identify patients who are medically well but cannot go home due to a housing or environment issue to provide solutions to enable safe hospital discharge. In 2023-2024 17 caseworkers across 17 principal hospitals achieved:

- 5,027 referrals, 4,104 people we directly supported with safe hospital discharge;
- 7,561 home adaptations and improvements to enable hospital discharge;
- 2,592 additional Healthy Home Checks to ensure long term support and recovery at home;
- Over 24,000 bed days saved.

The effectiveness of local authorities (primarily social services) in supporting safe, timely and efficient discharges from hospital;

In recent years, we have seen a noticeable increase in the number of Local Authority employed staff in hospitals across Wales in roles designed to support hospital discharge. For example, we work a lot with the Home First Team in ABUHB, Delta and PIVOT in HDUHB, and have a presence in the discharge hub in CTMUHB.

We generally work well in partnership with Local Authorities to provide a holistic package of support for older people who need to leave hospital. However, we want to strongly convey that the third sector plays an integral role in supporting both Local Authorities and hospitals to discharge patients safely back into the community. Without having the resources of the third sector to fall back on, Local Authorities would struggle to deliver essential works required to safely discharge a patient from hospital.

Care & Repair's service fills the gaps that local authorities and hospital staff cannot deliver. One Hospital to a Healthier Home caseworker based in the Royal Gwent told us: "Hand in hand Hospital to a Healthier Home and Home First work really well together, they have hospital based social workers with their expertise referring to us with our expertise, and I think it's a really good

system." Works frequently referred to us include home adaptations, furniture moving, key safe fitting and home safety checks like gas and electric, and excess cold.

However, there are some instances where system pressures get the better of the system, with several caseworkers articulating the complexity of cases the service can receive, as well as referrals that should go to Occupational Therapy or where social services are involved and refer to us despite knowing that the patient's environment isn't safe to go home in that hope that we will be able to provide solutions. This was articulated in the following ways:

> *"I have one case at the moment where the patient is still in hospital. The social worker asked for a handrail because of access to property. When I got there, there was no pathway to put rail on. The property derelict with no heating hot water, the patient had been showering with a garden hose. It's not fit for him to go back to. Why did the social worker only refer to the rail? They know we will go out and see the bigger picture"*

> *"Some things are not within our remit. Had a referral for patient in and out of hospital, we organised two deep cleans for this lady. The social worker met the Care & Repair handyman to let him in for electrical works for discharge; when we got there was no heating or hot water and obstruction to chair, no fridge freezer – the social worker had been out that morning and deemed okay for the lady to go home. We were able to go out and see client morning after discharge, took her blankets, and have provided heating. Questions about why we are doing it, why wasn't it picked up in the visit?"*

> *"I had a referral to visit a lady last week with complex disabilities, living with her daughter and two grandchildren. Her bed is in same room as granddaughter's bunk beds. She's stuck in bed, extremely cramped. The Local Authority had looked at extension but not enough room. We have been asked to look at it, but realistically what can we do? They can't afford to move. Four of them, three generations in three-bedroom house. This is a social worker's job."*

Increasingly we are seeing older people living with complex issues of disrepair, where a referral for a small adaptation assessment or fitting escalates to intense casework to attempt to make the home safe and suitable for recovery.

The scale of the current situation with delayed transfers of care from hospital (as attributable to the role of local authorities), including the typical length of delays;

Although we cannot speak on behalf of Local Authorities, we know that our service helps speed up safe hospital discharge and fills gaps in service provision that would otherwise lead to delays in discharge. In financial year 2023-24, the service completed over 7,500 home adaptations and

home improvements to a value of over £1.76 million, and saved the Welsh NHS over 24,000 bed days, directly supporting over 4,100 patients to leave hospital more quickly.

In the first six months of 2024-25, the service received 2,718 referrals to facilitate safe hospital discharge for older patients who are clinically optimised but cannot go home due to a housing or environmental issue. **The service reduces a patient's length of stay in hospital by 6 days on average.** Via our Hospital to a Healthier Home service, we have saved the Welsh NHS an additional 11,200 bed days in the first half of this financial year through speedier, safer hospital discharge.

Mindful to be conservative with our cost savings estimates, taking a standard bed day figure at £345[i], the Hospital to a Healthier Home service has saved the Welsh NHS £3.8m in the first six months of this financial year (2024/25) **alone** on bed days saved. This figure doesn't include the staff time and system efficiencies we have saved, or the cost savings associated with preventing readmission. We believe this makes for a strong case for recognising the tangible role the third sector plays within this system to enable safe hospital discharge and improve patient flow.

The main barriers for local authorities in effectively facilitating the discharge of patients with care and support needs, including:

Our Hospital to a Healthier Home service receives referrals to complete adaptations or adaptations assessments from local authority employed social workers regularly. Without Care & Repair, these issues would be a barrier to discharge as the home would not be suitable for the patient to be discharged into. Our service provides fast, practical solutions to issues that would otherwise go unresolved or take much longer to resolve. In particular, this often involves:

- Same day referrals for key safe fittings to allow a carer to access the property once a package of care has been put in place. If not done in a timely manner, this package of care goes to another patient and can result in long delays to discharge for a patient who is otherwise medically fit to go home.
- This is the same for moving furniture. We frequently receive urgent referrals for bed moves to create a safe environment for sleeping downstairs for patients who are being discharged but are less mobile.
- Small bathroom adaptations such as handrails around showers, to enable personal care as part of a package of care.
- Clean and clearance to enable safe movement around the house for both the patient and carer.
- Mobility aids like handrails, grab rails, ramps, stair rails.
- Maintenance issues at properties.

We are able to complete these works because our specialist Hospital to a Healthier Home caseworkers are able to leverage capital for works via our national Rapid Response Adaptation Programme, meaning we can respond to urgent requests for hospital discharge. Nationally our average for all adaptations via this programme is 14 days, but for a Hospital to a Healthier Home referral we can complete works the same day or next day. This demonstrates the importance of having specialist caseworkers bridging the gap between hospital and local authority.

Social care capacity and workforce shortages;

The feedback varied across Wales, however consistently caseworkers referred to challenges for care packages for patients living in rural areas with caseworkers covering a locality with both rural and urban areas particularly commenting on the difference even within the same local authority. Caseworkers from across Wales also noted increased instances of older people being discharged from hospital without a care package in place, with friends and family expected to fill the gaps whilst a care package is sourced.

Waits for care assessments (and other assessment related issues),

We cannot speak on the wait for care home assessments. However, all our H2HH caseworkers are Trusted Assessor qualified for assessment for adaptations. Guidance produced by NHS Exec can be unhelpful because it uses the term Trusted Assessor as a blanket term but can mean different things in different contexts, e.g., other third-sector organisations in the same area might employ staff under an umbrella term of Trusted Assessor but they are assessing very different things. This has put some additional pressure on our services in some areas where referrals are made to Trusted Assessors in other organisations who cannot complete assessments for adaptations – these referrals then come to us but indirectly from the hospital, making it more difficult to liaise with hospital staff around discharge planning and works schedule.

Challenges in arranging care home placements or home care packages, and

Our service is specifically about getting people out of hospital more quickly into their own homes. As mentioned in the paragraphs above, we support the timely provision of care home packages through our home improvements and adaptations, most commonly through key safes and small adaptations. However, sometimes we come across more challenging cases where

more intensive works are required to enable a package of care to go ahead requiring rigorous intervention work with both the patient and their home. Our caseworkers gave the following examples verbatim:

> *I am currently on a case where the gentleman has had an overcrowded property without heating. He has had a stroke and now needs a hospital bed, bariatric commode and steady with downstairs living. He has had repeated failed support from carers as they cannot use equipment safely, so he has sent them away through not allowing things to be moved and thrown. He has now allowed us to undertake a clearance that now allows us to look further into heating issues and allows for ample room for equipment for the care package to go ahead.*
>
> *I had a lady in the past who physically could only access one room of her property, her electrics were faulty and there were leaks all around the property. She couldn't mobilise around the property and she could not have had personal cares given. We did a mass exercise of clearing and giving to a cash for clothes which also aided in funding new white goods, then she could be discharged to receive care at home.*

Disagreements or legislative barriers affecting discharge decisions;

Care & Repair are not involved in this.

The variations in hospital discharge practices throughout Wales and the impact on local authority delivery. How to improve consistency, including the identification of best practice and innovative approaches that could be adopted more widely;

We believe H2HH is an example of best practice. The service has operated since 2019 and is currently funded locally by 5 LHBs or RPBs. Until recent months, this service has been funded annually in each health board following a successful Welsh Government pilot and embedding period, although following a tender process in one health board the service will funded for three years from April. However, in other health boards the service remains annually funded, despite a high referral rate, proven cost savings and strong outcomes. Over the years we have worked hard to develop relationships with hospital staff, and each year these relationships are at risk as our specialist H2HH Caseworkers must decide whether to leave and find more reliable employment or wait to see if the funding is renewed. This is particularly insecure given that for some health boards last year the funding wasn't confirmed until March for the financial year starting in April.

An assessment of current discharge processes and procedures at a local government and national level, including partnership working between the NHS and local authorities, strategies for increasing community capacity, and the effectiveness of Welsh Government support.

We would have liked to see mention of partnership with third sector included in this consultation. As evidenced in this response, our Hospital to a Healthier Home service is highly referred into and well used by hospital and local authority staff. Over time this service has become a trusted go-to for staff looking for solutions to problems. We undertook a three-year evaluation to understand the impact of the service and understand why hospital and local authority staff refer into it and found that staff use the service because it:

Eases hospital pressures by speeding up safe discharge:

"We had a new member of staff recently who moved from England, and she couldn't believe that we had a service that would go out the same day to do a key safe… that's why we add it into the introduction to the team because it's a pathway we use for a lot of our cases." Social Worker in the Joint Discharge Team, Withybush Hospital

"That pressure of flow in the hospital. Any kind of delay in length of stay, it just backs up and clogs up the whole system… by having these adaptations, it's reducing the need on the service, it's keeping people independent in their primary environment." Occupational Therapist Clinical Specialist, Bangor Hospital

Is an embedded and accessible service:

"[The H2HH caseworker] sits on our clinically optimized meetings weekly, and then we discuss any hurdles that there are for patients to go home, which quite often is a lot of the housing issues, whether it's cleaning or rails and so on," Site Matron, Neath Port Talbot Hospital

"[The service is] built into our initial assessment as a pathway onwards, that's how much kind of we use it. And it's actually a part of our team. As I started the role, it was introduced to me as a service that we use for patients to support discharge" Occupational Therapist, Medical Surgical Team Ysbyty Gwynedd

Has reliable communication:

"It's lovely to have those two-way conversations so that we know exactly what's happening. And we can feed back to the board, we've been asked all the questions all the time, you know, when things been done, equipment going in, etc. So I think having [the H2HH caseworker there] there as a point of contact and advice and keeping the momentum is really key," Occupational Therapist, YYF

Operates in partnership:

"One of the best things that we've had really is that [the H2HH caseworker's] visit the home sometimes, and she'll take photos, which has really been helpful for us in the hospital… then we can add that to our assessments here." Occupational Therapist, YYF

"He can look at things that we might not necessarily think of as well, I think he can see it from a different perspective. And think of different ways that we can get things resolved that we wouldn't be able to do. And a good example of that is things to do with cleanliness in properties deep cleans." Band 7 Occupational Therapist, Prince Charles Hospital

"As an OT, we would spend a lot of time trying to facilitate the minor adaptations key safes and trying to find grants and things for cleaning homes, which would remove our presence from the ward for doing rehab assessments ourselves. So if anything, you're allowing us to do our role to a better standard while we're able to just link them with you, just for a small window of our working day, and know that that's going to be sorted in the background and that we are getting those updates as we go along." Occupational Therapist, Ysbyty Eryri

The Hospital to a Healthier Home service is an integral part of enabling safe hospital discharge for older people, improving patient flow in hospitals, and reducing readmissions. Our housing expertise and ability to work in both hospital and community settings means we are able to offer a holistic approach to hospital discharge, considering and solving the needs of both the patient and the property.

For further information on the topics raised in our response, please contact:

faye.patton@careandrepair.org.uk

[i] Figure: £345 = Average cost of a standard bed day
Data and Methodology: using cost collection data for 2020/21, the most recently available data, the unit cost per day of NHS hospital beds is as follows: elective - £2,349; non-elective - £901; critical care - £1,881; standard bed - £345.
Ref: Written questions and answers - Written questions, answers and statements - UK Parliament

promoting equality in housing
hybu cydraddoldeb ym maes tai

Tai Pawb

Response to:

The role of local authorities in supporting hospital discharges

Local Government and Housing Committee

February 2025

Authors:

David Rowlands

For further information about this paper please contact:
Name: David Rowlands
Position: Policy Manager
Email: David@taipawb.org

Who we are

Tai Pawb (housing for all) is a registered charity and a company limited by guarantee. Our vision is a "Wales where everyone has the right to a good home." We operate a membership system which is open to local authorities, registered social landlords, third (voluntary) sector organisations, other housing interests and individuals.

What we do

Tai Pawb works closely with the Welsh Government and other key partners on national housing strategies and key working groups, to ensure that equality is an inherent consideration in national strategic development and implementation. The organisation also provides practical advice and assistance to its members on a range of equality and diversity issues in housing and related services, including QED – the equality and diversity accreditation for the housing sector. We are also part of a coalition called "Back the Bill", which seeks to establish the legal right to adequate housing for **all citizens** in Wales.

For further information visit: **www.taipawb.org**

Charity registration no. 1110078
Company No. 5282554

1. Introduction

1.1 In recent years, hospital discharge has been openly discussed in the media. Problems deriding from 'bed blocking' have a profound effect – not just in terms of the impact on the individual but also the wider health system. Prolonged discharges are costly to the NHS but also impact the treatment of other patients.

1.2 The Welsh Government's White Paper on ending homelessness, published in 2023 highlighted proposals relating to discharge in order to prevent homelessness. Given the expected publication of these proposals later this year, this Committee inquiry is timely as we look for answers to help solve interconnected problems.

1.3 We recognise the focus of the inquiry on local authorities. Therefore, this response will seek to add value by focusing on specific areas of Tai Pawb's expertise, our work on accessible housing registers and homelessness. We conclude by highlighting the need for systems change through the full incorporation of the right to adequate housing in Wales.

2. Accessible Housing Registers

2.1 In 2021, Tai Pawb undertook research into Accessible Social Housing in Gwent, reviewing allocation systems. This report looked at allocations for accessible housing in the broadest sense, including in relation to hospital discharges. The report highlights how the investment of time and resources into the effective allocation, operational and strategic processes for accessible housing can have a substantial impact on people's long-term health and well-being, the prevention of hospital admissions, and can enable better and more timely discharge of people from hospital. Such investment has the added benefit of large cost savings.

2.2 The report identified many examples of good practice of joint working between housing, health, and social care staff. However, there were some concerns regarding the effectiveness of communication, referrals between partners and an integrated approach to meeting disabled people's housing needs. Health and housing staff identified a need to improve joint operational working for hospital discharge. There was support for improved strategic consideration of accessible housing need and allocation, and the impact of gaps on disabled people and services. A regional framework on accessible housing allocation could help strategic planning and enable better joint working to address gaps. Health, housing, and social care staff identified a need for more step-down accessible accommodation to enable safe and timely discharge from hospital. There was significant support for more and better coordinated 'hospital to home' discharge services to support patients to apply for accessible housing, meet patients' housing needs and to link with social landlords. There were strong arguments for earlier referrals to housing from health staff and a more holistic consideration of patients housing accessibility and other housing needs.

2.3 The specific recommendations relating to discharge were as follows:

- Review and investment in a variety of step down and temporary accessible housing facilities
- Commission a housing focused hospital discharge service (align and address gaps in existing housing and social care discharge and admission prevention services)
- Develop clear hospital discharge pathways including increased focus on early referrals to and communication with housing

2.4 We would urge the Committee and local authorities to consider this report and its findings when making recommendations.

3. Discharge and Hidden Homelessness

3.1 In 2023, Tai Pawb undertook research on people with protected characteristics experiences of homelessness. We spoke to thirty-six people across different equalities groups, including some with more than one protected characteristic. One participant's experience is outlined as a case study below:

"Anna (not he real name) has brittle bones and experiences chronic pain. She lives with her long-term partner, but while recuperating from a leg break in hospital, he decided to separate and sell the family home. On hospital discharge, **no help was offered** and there was no option other than to move in with her daughter. Anna spent the next 18 months sleeping on a sofa. During this period, while the council staff were understanding of her problem, they were unable to help. Anna 'bid' for plenty of social lets but was unsuccessful. No suitable properties were available on the private rental market leading to Air BnB being considered as a last resort. When Anna's original family home sold, rather than improve her situation, it made it worse as the money she received was considered to be "significant," lowering the banding at which Anna was placed at in the social housing waiting list. Aged seventy, with a sole income of benefits, Anna was unable to get a mortgage or afford to buy a suitable property. Rather than her impairment, the funds from the sale were considered more important to her housing situation which Anna felt was like "indirect discrimination." Eventually, with the support of a local charity and intervention of a Head of Housing, Anna moved into a social let. Reflecting on her experiences, Anna felt "if someone had listened and looked at the bigger picture, perhaps a better understanding would have resulted in a quicker process."

3.2 This case study highlights that lack of appropriate mechanisms in place at discharge – doesn't just lead to bed blocking and prolonged stays in hospital. They can also lead to 'hidden homelessness,' further health problems and cost to the individual as well as the NHS. When reviewing discharges from hospitals, research by Care & Repair Cymru identified that investing £1 in the Rapid Response Adaptation Programme, which facilitates home adaptations to

enable hospital patients to return home safely, can generate £7.50 savings in health and social care budgets. Investment in more accessible homes and adaptations are therefore essential in preventing further accidents, which can prove costly to individuals and the NHS. Hospital discharge is a key moment to ensure someone has the safe and suitable home they need.

3.3 The upcoming Welsh Government proposals to reform homelessness legislation have the potential to impact discharges, including an expected duty to refer people at risk of homelessness to support within the Local Authority. To succeed, these will require cultural and process changes amongst hospital staff. We await the upcoming legislative proposals with anticipation and are happy to work with the Local Government and Housing Committee to help scrutinise and add value to these.

4. The right to adequate housing – a case for systems change

4.1 In Autumn 2024, the new First Minister identified 'A Healthier Wales' as one of the key priorities of Government, including cutting NHS waiting times. Wales is an increasingly ageing nation – with expected higher rates of disability in the future. To achieve a healthier nation in a long-term and sustainable way, will require system change.

4.2 Housing currently averages since 2006, only 2.2% of Welsh Government budgets. This is despite the fact that evidence highlights how poor housing costs the NHS, and conversely investment in housing improves lives and saves the NHS money. The demographic changes to the population of Wales over the short-medium term further highlights the need for change. If we don't - public spending in Wales will continue to be dominated by the NHS and hospitals.

4.3 Tai Pawb are part of the Back the Bill campaign, which seeks to incorporate a right to adequate housing in Wales. This would make a good home a right – boosting supply of homes needed, increasing investment, and returning housing to a fundamental mission of government. In relation to hospital discharges, a right to adequate housing could:

- Prevent accidents in the first place through more funding for adaptations in the home.
- Increase the supply of accessible homes.
- Ensure 'upstream policy changes' by highlighting the importance of a good home to people's health and lives.
- Change work processes and cultural practices around multi-agency working, highlighting the importance of housing as partners to the NHS, including around discharges.
- Increase the role of disabled people's voice in developing appropriate housing.

5. Conclusion

5.1 Improving the hospital discharge process can help improve lives and cut costs for the NHS. This response highlights considerations, as well as potential solutions for achieving this.

5.2 Upcoming legislative changes are an opportunity to improve practice, with greater partnership working between the NHS and local authorities. To succeed, this will need to be accompanied by investment, resources, and changes in culture and practices from all stakeholders.

5.3 Given the changes to Wales population likely to happen over the next decade or so, we believe this inquiry highlights the need for a systems change in health and housing in Wales. We believe this is best delivered through incorporation of a right to adequate housing.

The role of local authorities in supporting hospital discharge

A RESPONSE FROM WCVA

1) Wales Council for Voluntary Action (WCVA) is the national membership organisation for the voluntary sector in Wales, Our purpose is to enable voluntary organisations to make a bigger difference together. WCVA's Health and Care Project aims to better connect the voluntary sector with the health and social care system.

2) We thank the Committee for the opportunity to respond to this consultation on the role of local authorities in supporting hospital discharge.

3) There is a strong foundation of voluntary sector organisations delivering home from hospital services for well over 20 years. Despite this longstanding and current contribution, voluntary sector hospital to home services are often not integrated into the planning of hospital to home pathways. They are frequently reliant on short term funding and at risk of closure year on year.

4) People with learning disabilities, autism and older people are more susceptible to delayed hospital discharge. Our commissioned literature review by University of South Wales found that this was largely due to the unavailability of suitable packages of care and that systemic issues were a contributing factor in delayed discharge. The report also found that the voluntary sector plays a key role in:
    - Partnership and joint working e.g. discharge support workers
    - Commissioned services that enable safe discharge e.g. adaptations and transport
    - Services that prevent readmission e.g. supporting activities of daily living and social support

SUMMARY OF RECOMMENDATIONS

5) Our recommendations in the area of hospital discharge are:

- Public sector services should value and trust the voluntary sector as one of the cornerstones of the health and social care system, and collaborate with them as delivery partners of the Discharge to Recover and Assess Model of Care.
- The statutory sector should engage in early and continuous dialogue with the voluntary sector to ensure resources are allocated efficiently to meet patient need.
- Longer-term contracts should be awarded for delivering hospital to home services, adhering to the National Framework for Commissioning Social Care and the Code of Practice for Funding the Third Sector.
- Local authorities should experiment with different collaborative commissioning approaches, co-producing the approach and delivery with the voluntary sector to create more social value.
- Local Authorities should do things differently, focusing on people and community benefits as a priority, this is possible within the parameters of their procurement process.
- All public bodies funding or commissioning services from the voluntary sector should do so in accordance with the Code of Practice for Funding the Third Sector. The Code outlines best practice, reduces the bureaucratic burden for public funders and voluntary organisations alike, ensuring efficient delivery and better value. An updated version of this Code will be published shortly.
- Cross-sector stakeholders actively collaborate with the voluntary sector to co-design and implement an integrated volunteering pathway that supports individuals from hospital to home.
- Learn from existing examples of effective volunteering frameworks and roles.

These are expanded upon later in this response.

VOLUNTEERS AND VOLUNTEERING

6) Volunteers are uniquely placed to work across public and voluntary sector boundaries, bridging the gaps between health and social care provision.

7) In Wales, Local Authority representatives on Regional Partnership Boards (RPBs) can advocate for increased volunteering funding by showing how it eases pressure on local resources and strengthens community support, using evidence of impact, as shown in the below examples:

8) Volunteers in hospital settings can play a key role in patient discharge and overall patient support. Helpforce UK's report notes that "volunteer action has saved staff time. For example, collecting medicines from the pharmacy for patients to take home yielded 29 minutes of time per collection and sped up the patient discharge process by an average of 44 minutes per patient". This free up clinical and nursing staff to spend more time achieving better outcomes for patients.

9) Volunteers can also help prevent patients from being readmitted to hospital unnecessarily. The report highlights a scheme in Kingston in which patients received

discharge support calls from volunteers, lowering readmission rates and improving people's level of confidence to cope at home.

10) Helpforce have also highlighted several other schemes across the UK in which volunteers make a positive impact on hospital discharge.

- Sussex Integrated Care Board (ICB) introduced 'reconditioning volunteers' to encourage mobility and prevent muscle loss. This helped patients recover faster and enabled quicker discharge.
- Cornwall's Community Gateway and hub network provided 365-day community support, reducing unnecessary healthcare visits by 50%. Following the success of the pilot, Cornwall and Isles of Scilly ICB committed £700,000 funding per year for three years to the Community Gateway and hub network, shifting care from hospitals into the community.
- Within the North East and North Cumbria ICB's 'Settle at Home' service, NHS volunteers act as a bridge between hospital and voluntary sector support. This ensures patients have necessary support post-discharge, reducing risks of readmission.

11) Investing in volunteer-led initiatives can:
    - Improve discharge efficiency and patient outcomes.
    - Reduce hospital readmissions and healthcare costs.
    - Strengthen community support networks, easing pressure on health services.

12) Ongoing research and integrated partnerships are key to sustaining and expanding these benefits.

Recommendation: Voluntary sector, Local Authorities and the Health Boards must actively collaborate to co-design and integrate volunteer roles into health and social care pathways that supports individuals from hospital to home. This coordinated approach ensures that volunteering services are embedded across all care settings, enhancing patient well-being and continuity of support within both hospital and community environments.

Recommendation: Learn from existing examples of effective volunteering frameworks and roles:

a. **Helpforce 'Back to Health framework guide'** and the **Framework for volunteering in health and social care**
b. **Work in partnership with volunteering experts to overcome policy and practice barriers**. Policies are often designed for the workforce, not with volunteering in mind. Helpforce has partnered with cross-sector stakeholders to remove barriers and ensure safe volunteering from hospital to home. For example, safeguards, including revised data protection and information-

sharing protocols, enable volunteers to call patients and reduce DNAs (did not attends).

FRAGMENTATION

13) Whilst hospital to home services are an ongoing requirement to support hospital discharge processes and meet patient needs, voluntary sector provision across all parts of Wales are variable, driven by both local and regional arrangements. The Regional Integrated Fund (RIF) aims to improve integration therefore innovation projects should be funded through it. However, local authorities and health boards may have commissioned services separate to RIF from their own budgets.

14) This fragmented approach should be reviewed and a more joined up approach involving the voluntary sector should be established. The new approach should be about allocating resources in a strategic and collaborative way that does not continue the cycle of annual contracts and grant pots to fund the voluntary sector.

Recommendation: The statutory sector should engage in early and continuous dialogue with the voluntary sector to ensure resources are allocated efficiently to meet patient need.

15) Welsh Government has developed the D2RA (Discharge to Recover then Assess) pathway. This sets out four main pathways for supporting people during the hospital to home process.

16) Health Boards and Local Authorities currently fund/commission hospital to home services delivered by the voluntary sector to provide support across pathways 0 to 2, but there is a lack of clarity about what is needed from the voluntary sector at a minimum to ensure safe discharge. The Hospital to Home Community of Practice (CoP) has continued to develop the Model of Care, based upon good practice activity funded through the Regional Integration Fund and other work considered important to the Model. The sector's role is valued within the CoP but there are unanswered questions about what is expected from it as part of this model.

17) Without the voluntary sector, statutory partners would be unable to meet their statutory duties for care and support. Unpaid carers and families would be expected to provide the support the voluntary sector often provides. These roles range from providing home care and transport to ensuring that patients' homes are adapted to their needs. Although not mentioned in the consultation, the voluntary sector is a vital partner in ensuring that local authorities are able to successfully plan and deliver hospital discharge processes. Unfortunately, there is a postcode lottery in terms of what the voluntary sector provides due to the uncertain and fragmented funding.

Recommendation: Public sector services should value and trust the voluntary sector as one of the cornerstones of the health and social care system, and

collaborate with them as delivery partners of the Discharge to Recover and Assess Model of Care.

STRATEGIC PARTNERSHIP

18) Hospital discharge is complex and requires an effective multi-agency, person-centred approach. This entails continuous dialogue between the voluntary sector and statutory agencies, working together to plan the services required to meet population need.

19) Hospital discharge is the intersection between health and social care which means that RPBs have strategic oversight of hospital to home support services. Progress has been made in improving the integration of health board and social services, but there are still challenges in allocation of resource and communication between them.

20) Not involving the voluntary sector in discussions about planning hospital to home provision is a mistake. They can join dots, contribute creative ideas and represent patient voices. Not only are voluntary sector partners not routinely included in planning, there is also a lack of support and capacity for voluntary sector representatives to engage with RPBs strategically. Voluntary sector representatives' time spent engaging in strategic structures is often funded from charitable or unrestricted funds in their budgets. Greater resource is required to allow the voluntary sector to play its role on RPBs more effectively.

21) There is also a need for many RPBs to undergo a change in attitude and view the sector as critical delivery partners in their work. Whilst the voluntary sector holds no statutory duties, it supports the public sector to meet its statutory duty. This should be valued and respected but many voluntary sector representatives are viewed as 'junior partners' on RPBs, and their presence and perspective are not valued equally in decision-making.

22) Local and regional voluntary sector organisations tend to provide services closer to home and have a better understanding of local needs and needs of specific population groups. These are too often overlooked when it comes to involvement in joint service delivery and partnership arrangements. The Third Sector Support Wales network is well placed to facilitate the engagement of voluntary sector groups and organisations within integrated systems to address gaps in provision, particularly for underserved communities, and involve volunteers to develop capacity within communities.

COMMUNICATION AND COLLABORATION

23) The voluntary sector provides support to patients and their families. The specialised support provided to unpaid carers can especially help to ensure a safe discharge and reduce the risk of readmission. The voluntary sector can be a linchpin for families and support specifically for unpaid carers can include emotional support groups, transportation, or even volunteer-led assistance with household tasks.

24) Communication between hospitals and social care could be improved at the delivery level. In some areas, hospital discharge social workers are not based within discharge teams. If they were, it would encourage earlier conversation about patients' needs. This manner of planning and collaboration with the patient gives them the voice and control required under the Social Services and Wellbeing (Wales) Act. Early and continuous dialogue with the voluntary sector on discharge planning would help identify suitable community-based support earlier and allow for a much earlier and safer discharge date.

25) There are reports of hospital ward staff being unaware of voluntary sector services local to them. The strategic programme for Primary Care has a Multi Professional workstream which is trying to make improvements and reduce siloed working. However, the voluntary sector is not routinely invited to help spread and embed this practice across health boards. Involving voluntary sector partners in multi-disciplinary discussions would lead to better awareness of the support services available.

RESOURCE

26) Hospital to home services delivered by the voluntary sector have been annually funded for the past 20 plus years. Considering the oversight required to manage annual contracts for an essential part of the health and care system this represents a significant amount of waste over time. Where the voluntary sector is meeting a population need, a more strategic approach must be taken to allocate resource rather than run competitive tenders.

Recommendation: Longer-term contracts should be awarded for delivering hospital to home services, adhering to the National Framework for Commissioning Social Care and the Code of Practice for Funding the Third Sector.

27) The National Framework for Commissioning Social Care is an opportunity to start doing things differently. Too often enthusiastic people in the voluntary sector and staff in commissioning teams are met with barriers as a result of legislation, procurement process and culture. Resourcing of time for working productively with the voluntary sector on commissioning differently would be welcomed.

Recommendation: Local authorities should experiment with different collaborative commissioning approaches, co-producing the approach and delivery with the voluntary sector to create more social value.

Recommendation: Local Authorities should to do things differently, focusing on people and community benefits as a priority, this is possible within the parameters of their procurement process.

28) The increase in National Insurance Contributions the voluntary sector will have to pay will only add to this instability. There is a serious risk of organisations closing their doors entirely, leading to further delays in the successful discharge of patients back into the community and an increase in the likelihood of them returning to hospital due to a lack of community care. Many Senedd committees have shown similar concerns to WCVA's on this.

Recommendation: All public bodies funding or commissioning services from the voluntary sector should do so in accordance with the Code of Practice for Funding the Third Sector. The Code outlines best practice, reduces the bureaucratic burden for public funders and voluntary organisations alike, ensuring efficient delivery and better value. An updated version of this Code will be published shortly

CASE STUDIES

29) Here are three short case studies to highlight further the crucial work the sector in Wales does in this space.

30) CASE STUDY: Powys Association of Voluntary Organisations run a Community Connectors programme. The Community Connectors provide signposting support following a 'what matters' holistic conversation to patients being discharged home from hospital or recently discharged home. They attend MDT meetings, Patient Flow meetings and Care Practice Forum, inputting voluntary sector information into discussions with statutory services, aiming to achieve positive outcomes.

31) CASE STUDY: Age Connects Morgannwg run the Better@Home Project. This provides someone who has been recently discharged from hospital with six to eight weeks of support from a support worker and a two-week shopping service. It also offers volunteer transport to help people to medical appointments, as well as a befriending service for those who may be more socially isolated.

32) CASE STUDY: Care and Repair have been delivering Hospital to a Healthier Home across Wales since 2019. Specialist caseworkers work with clinical staff to identify patients who are clinically optimised but cannot go home due to a housing or environmental issue. The service fits home adaptations and completes home improvements to ensure patients can leave hospital more quickly into safe, warm, accessible homes. Since the beginning of the service, Care and Repair has completed

more than £8m in home improvements to facilitate safe discharges and help prevent readmission. This helped over 20,000 patients leave hospital more quickly, and saved the Welsh NHS over 120,000 bed days. However, they report that they frequently see patients discharged back into homes that are hazardous and likely to cause readmission, especially around falls and cold risks

33) WCVA will be happy to discuss these matters further with Members of the Senedd or officials on request. We thank the organisations who have contributed information to develop this response.

Johanna Davies
WCVA Head of Health and Social Care
jdavies@wcva.cymru
February 2025

Care Forum Wales response to the Local Government and Housing Committee Inquiry on the role of local authorities in supporting hospital discharges

The effectiveness of local authorities (primarily social services) in supporting safe, timely and efficient discharges from hospital

1. It is difficult to comment separately on the role of local authorities from that of local health boards, given the increasing involvement of multi-disciplinary teams and different practices. For instance, the role of the Trusted Assessor is interpreted in different ways, with some regions having dedicated roles, others absorbing the functions within existing posts.

The scale of the current situation with delayed transfers of care from hospital (as attributable to the role of local authorities), including the typical length of delays.

2. Whilst the pattern of delays varies across Wales, Care Forum Wales has recently undertaken some analysis of the publicly available data from Stats Wales that shows a corelation between the number of delayed transfers and local attitudes and relationships, rather than being driven by processes. This is described in more detail below.

Social care capacity and workforce shortages

3. In general, the main delays in the assessment process appear to arise from shortages of social workers which can result in an individual being stuck in hospital until one becomes available to assess their eligible needs. Further delays can then occur where follow up conversations are required during periods of absence, due to lack of cover for holidays etc.

4. The staffing situation within the independent sector has possibly improved, but we are still a long way from the pay and progression framework that we need to prevent the drift of staff to the statutory sector. Whilst the Welsh Government commitment to the Real Living Wage is appreciated, it still does not enable the sector to compete with local authorities (and health boards) who pay their own staff at a higher rate than they use in costing commissioned care. Furthermore, the Real Living Wage funding for 2024-5 did not reach the sector in all areas and, because it is not ringfenced, some councils have used it for other purposes such as libraries and teachers' salaries. Whilst Welsh Government has repeatedly told the National Provider Forum for Wales that they provided funding for RLW last year, WLGA has said that the funding has been insufficient and nobody has taken responsibility for resolving the issue.

5. The staffing situation is very reliant on overseas workers in some areas, which is becoming increasingly problematic as a result of sponsorship limitations from UK Government and the need to provide guaranteed income to comply with sponsorship licences. This is particularly difficult in home care which is, for the main part, spot purchased by local authority commissioners rather than purchased under block contract and hours are therefore not guaranteed. In areas such as Cardiff, there has been an influx of new home care companies coming into the market and competing for hours which makes it even more difficult to offer employees guaranteed hours.

6. We anticipate that the impact of the massive increases in Employer National Insurance Contributions from April will result in care providers selling up or having to make redundancies. Care Forum Wales is conducting a survey of members at the moment to better understand the situation, but it likely that the staffing situation will only get worse. Given the exemption by UK Government to the statutory sector and the additional funding for local authorities and health boards, there is a likelihood of recruitment exercises that will be very attractive for care workers seeking job security.

Waits for care assessments (and other assessment related issues)

7. Delays around social worker availability have been detailed at 3 above. Members also say that the removal of social care workers from hospitals has contributed to delays and re-admissions because they usually have better understanding of someone's holistic needs and what care homes can offer.

8. Poor communication and disputes often occur where communications have been undertaken verbally rather than in writing.

9. Delays can occur in the Registered Manager carrying out their own assessment on an individual in hospital, to confirm that the setting has sufficient staff with the right skills to meet their needs. There are a number of reasons for this, one being the frustration and wasted time experienced as a result of local authority inviting too many other providers to assess.

10. A further deterrent against taking an individual direct from hospital is the frequency with which an individual's needs are under assessed. This creates immense difficulties for the provider who may be unable to provide the level of care required or if able to do so, will not receive adequate payment to cover the additional care hours. It also, of course, puts the individual at risk of not having their needs safely met and facing the traumatic experience of having to be re-admitted to hospital or move to another care home. This can be a result of the hospital assessment being less thorough than the provider's assessment, or the result of someone's needs manifesting more clearly in a care home environment, but is compounded by difficulties in obtaining a re-assessment.

11. More worrying still, there are some areas where people's needs appear to be regularly under stated (see below) resulting in mistrust and reluctance to take new admissions direct from hospitals.

12. Some care homes will accept residents who have greater needs than they would normally accept on the basis that they will receive wrap around support from health. However, this can be difficult to obtain, especially out of hours (e.g. District Nurses and out of hours GP services) and is resulting in some homes being more risk averse in who they admit. Home care workers experience similar difficulties in getting a response from community health services such as GPs.

Challenges in arranging care home placements or home care packages

13. The key issue is how care is commissioned and funded. There is a massive post code lottery in the fees that different local authorities are willing to pay for the care of people with the same level of assessed needs. This is most obvious in the standard fees paid to older people's care homes. For instance, there is an annual difference of £12,338 in basic older people's residential care between Flintshire and Cardiff in what is paid for just one bed. For an average size care home of 37 beds, this equates to a difference of £456,507. Nor is it a simple North-South divide, but sometimes just across local authority borders. The long-standing issues with underfunding have brought many providers to the point where they are no longer able to break even or to extend borrowing. This is adding to reluctance in taking on new residents direct from hospital, particularly where the individual has health needs that require more hours of care and nurse input. To make matters worse, several local authorities who fail to pay the actual cost of care are now also seeking to prevent providers from agreeing additional payments with families that they need to remain sustainable.

14. In home care, packages are often based on cost rather than outcomes and may not be sufficient to pay travel time.

15. There are likewise problems in the commissioning of residential care for younger adults with mental health and learning disabilities. Many individuals require 24/7 supervision, more intensive activities and access to social opportunities, meaning substantial care hours and cost. Yet we have heard from several members that if an individual is placed with them by the social worker according to their assessment of needs, it is not uncommon for the commissioning office to later argue that the social worker did not have the authority to accept the level of fee and to refuse to pay the arrears. Indeed, many of our members have spoken about substantial arrears accruing and non-existent increases over a period of time. The majority of councils (and health boards) refuse to

commission via the National Collaborative Framework because it produces figures that are higher than they are prepared to spend.

16. In the absence of a national model for agreeing Continuing Health Care, several health boards fix the rate they pay to care homes to correspond to the equivalent of the (already flawed) local authority rate plus the Funded Nursing Care element. Consequently, an individual with the most complex needs, requiring more care hours and more nurse input, receives no additional funding than if they were assessed for FNC. Betsi Cadwaladr University Health Board has given a standard increase of 6% to care homes, but in Conway where the Local Authority is an outlier in terms of fee increases, this results in a lower fee for CHC than FNC.

Disagreements or legislative barriers affecting discharge decisions

17. Disputes between health boards and local authorities regarding assessed needs are common and providers are likely to receive different versions of someone's needs according to who is paying.

18. Providers report that the individual described in the needs assessment by the commissioner (be it health board or local authority) often fails to match the individual who arrives in the care home.

19. The biggest issue for providers of older people's care is where an individual's nursing needs are under-assessed, which appears to be a deliberate tactic by some Local Health Boards to protect their own budgets at the expense of the Local Authority, the provider and the individual. In the case of the individual, this puts them at risk of unsafe discharge and deprives them of the right to free health care. There is a feeling that social care staff do not feel sufficiently qualified to challenge clinical decisions, although they often have a better understanding of the wider needs of the individual.

20. Local Authorities may also under-assess an individual who needs more intense care e.g. where they have dementia and particularly in terms of younger adult care.

How to improve consistency, best practice and innovative approaches that could be adopted more widely

21. Betsi Cadwaladr University Health Board is working with providers to deliver training to staff to improve understanding of the issues around hospital discharges.

22. Extending access to NHSemail to providers (as in other parts of the UK) would not only improve the speed and safety of the discharge process, but the long term care of the individual.

23. providers use a detailed form when carrying out an assessment that complies with the requirements of the Social Services and Wellbeing (Wales) Act 2014. It may improve the quality and consistency if this form were to be adopted by discharge teams.

24. Providers are more likely to take people from hospital if the placing authority is reliable. At times, an admission will be delayed or may even be sent to another home (especially if it is a local authority's own home) without warning or even communication, leaving the care home with an empty bed that they could have offered to someone else in need.

25. Two health boards commission Continuing Health Care more effectively and fairly than the others. Cardiff and Vale University Health Board commission each placement based on the needs of the individual. Aneurin Bevan pay an additional CHC premium on top of the Funded Nursing Care element to ensure that there is always a differential to reflect the greater complexity and cost. It is no coincidence that there are fewer issues with delays in these areas and that the overall relationship is much stronger.

26. Local Authorities should follow the spirit of the new National Commissioning Framework in working in partnership and engaging with providers in understanding cost. Greater transparency and a realistic fee would go a long way towards resolving delayed admissions to care homes. There is a corelation between those local authorities that pay the lowest fees and the highest numbers of people awaiting discharge to a care home. Whilst the financial constraints affect all councils, the vast difference in what they pay demonstrates that it can be done where there is a willingness and a genuine concern for the individual's welfare.

Current discharge processes and procedures, strategies for increasing community capacity, and the effectiveness of Welsh Government support.

27. We see little evidence of Welsh Government grant funding reaching the independent sector via the Regional Partnership Boards, in particular with regard to creation of step up/step down facilities and reablement services. Many of the "new" models of care appear to be simple extensions of existing statutory services. For instance, the majority of reablement services appear to be delivered by in-house teams rather than being contracted to home care agencies. Providers often say that local authorities "cherry pick" clients and leave those with the most challenging behaviours to commissioned services. This is not just an economic issue, but it means that care workers are dealing with some of the most stressful and less satisfying situations. Worse still, there is a

wider possibility that unregistered Personal Assistants and Microcarers may pick up some of the cases that are rejected by regulated care companies as being too complex even for their skilled and qualified staff.

28. Using care homes to provide step up/step down packages is most successful when a council is willing to block contract so that the home has financial security that enables them to reserve beds for short term clients. However, not all councils are willing to commission in this way in case the beds are not required and continue to spot purchase as the need for a bed arises. From the care home point of view, a short-term package is only viable if the council will guarantee funding for a fixed amount of time. In fact, many short-term packages end up becoming permanent by default, but without the benefit of the contract being reviewed to reflect emerging needs that may require additional funding.

29. The rebalancing agenda is having unintended consequences that are threatening to unbalance the sector. Much of the grant funding for accommodation with care is being used to build in-house provision, often where it is not needed because there is plenty of capacity within local care homes. For instance, Carmarthenshire County Council are using council reserves and Welsh Government grant funding to build a new care home at a cost of £19.5m to increase community capacity. However, there are several care homes in that area with vacancies – one within 4 miles that has 20 vacancies – often as a result of funding disputes. Care homes in the area need admissions in order to remain viable, yet the local authority pays a low fee (approximately £240 less per week than the Council estimates its own running costs) and then refuses to place people in homes that have asked for a small additional payment just to break even. Building is going ahead in other council areas with a similar history of low fees for commissioned care, including Flintshire.

30. In some areas, members have told us that families of prospective residents have spoken of not being given a care home's details on the list of homes supplied by the local authorities or of being advised that the home is too expensive.

31. There is a growing feeling amongst providers that some councils are prejudiced against the private sector and that some are even acting more like competitors than commissioners. According to Christie & Co's Wales Healthcare Market Insight Report 2024 40 care homes left the market between 2020 and 2023, with only 4 new homes replacing them. Unless the sector is properly funded and treated as a valued partner, we are in danger of losing much of the capacity that we do have.

32. We would be happy to share the data that we have collated around the post code lottery and the corelation with levels of delayed discharges.

British Association of Social Work Cymru
Written response to the Local Government and Housing

The role of local authorities in supporting hospital discharge

Foreword

BASW Cymru warmly welcome the opportunity to submit evidence on the role of local authorities in supporting hospital discharges. As the leading professional association for social work and social workers, BASW Cymru have consulted extensively with members to draw upon their front-line experience to ensure the voice of practitioners is heard. In addition, we draw upon research undertaken by BASW: Social work in NHS hospitals: Opportunities and challenges[1].

In 2022-23, there were around 18.3 million admissions to NHS hospitals across the UK, which equates to around 27,105 admissions per 100,000 population. Hospital admission is therefore a relatively common experience, and for many people will be a brief event from which they quickly recover. However, a hospital admission may also arise from an illness or injury with a longer recovery period, or from a long-term illness or disability. For some people, a discharge from hospital becomes an important opportunity to plan and organise the support needed to maintain the individual's wellbeing. Ward staff, other clinical staff, families or the patient themselves may make a referral for adult social care, before, during or after the admission. Only a small proportion of hospital patients will be referred to adult social care, and, other than the overarching principle that referral should be made when a patient's discharge from hospital is likely to be hindered due to significant social care needs that warrant assessment and support[2] from the local authority, there are no standard referral criteria.

Recommendations for Policy and Practice

I. Develop the professional identity of social work in healthcare settings. Social workers across healthcare settings, including acute hospitals, should be able to articulate their value to patients and to organisations, beyond the monetary value of expediating discharges. A focus on care ethics, practice models and methodology underpinned by legislation is essential to support social workers to develop a sense of their value base and the unique perspectives they can bring to bear when an individual is in hospital or ready to leave hospital.

2. Maintain (or reintroduce) a social work presence in acute hospital settings. Even if Discharge to Assess becomes the dominant model of progression from an acute hospital setting, social work skills are vital to ensure that rights and choice are upheld and that there is minimal negative impact on relationships and wellbeing. Social work support continues to be most important at the point of considering long-term plans following a hospital admission,

[1] Social work in NHS hospitals: Opportunities and challenges | BASW
[2] Social Services and Well-being (Wales) Act 2014 provides the legal framework for eligibility and assessment criteria

however decisions made in the short-term have an impact on the options available later, and so short-term decisions should not be regarded as trivial.

3. Promote the value of social work skills in the hospital setting such as therapeutic support to individuals and families facing change, social work specific practice models and methodology, safeguarding adults at risk of harm; and supporting the education of clinical colleagues, to reinforce a holistic approach from the health system.

4. Develop robust systems for appropriate information-sharing, that protect patient confidentiality but minimise the burden of seeking information about a patients' health or social care needs. This might be done by way of reciprocal read-only access to hospital and social service note-taking systems.

5. Ensure that Discharge to Assess models are sufficiently resourced to give meaningful opportunity for rehabilitation, recuperation and long-term assessment. Models based on residential care must maximise independence in a meaningful and risk-positive way and not miss out essential life-skills such as access to cooking facilities, medications, or travel in the wider community.

6. Named Social Worker for every patient. The inquiry should look to investigate the potential to develop 'named social worker' protocols for people with discharge needs. This will reduce bureaucracy, ensure continuity of care and person centered care and remove the sense of 'throughput' through the system.

7. Protected workspace within the hospital for social work staff. Hospital social workers are not always based in the hospital they support, yet data suggests that some social work staff are working in unsatisfactory conditions within the hospital, which limits their access to patients and family to gather the information they need, and also their ability to form good working relationships with clinical colleagues.

Understanding the hospital social work role

One of the key roles for social workers in acute NHS hospitals is to assess the needs of individuals and to organise social care support for after discharge from hospital. This can range from arranging relatively simple practical support (such as providing information about services), through negotiating different funding streams from health and social care budgets, to supporting complex assessments of risk and of mental capacity. Social workers contribute by bringing knowledge of resources outside of the hospital, as well as specialist knowledge around key legislation, particularly mental capacity legislation.

Social workers often take a position outside of the professional hierarchy of the NHS, and this can have advantages when it comes to providing an independent point of view from that of clinical colleagues. This ability (and professional responsibility) to challenge may be enhanced by the usual position of a social worker employed by the local authority rather than directly by the NHS. Different stakeholders in the discharge plans often have different opinions of what is and is not acceptable risk. However, a consistent finding within the research[3] [4] [5] has been the importance of social workers in advocating for patients and families in the hospital setting, centering discussion on the patient's wishes. Alongside assessment, discharge planning, and advocacy, hospital social workers may also be involved in a range of other professional activities, such as safeguarding adults, education (for both colleagues and patients) and therapeutic support to patients and carers.

Views of hospital social work

Social workers often report feeling like social work falls outside of the core work of an acute hospital, and as such it can be difficult to be accepted by the hospital administration or by clinical colleagues. In contrast, clinical staff often appear to highly value the support that social workers give to their patients, citing their ability to advocate for the patient and to navigate complex social care systems outside of the hospital, although in our research[6] clinical staff did mention that social work input can also feel like a disruption to the smooth running of a ward. Evidence about patient and family views of hospital social work is more limited. However, social workers are recognised by patients with helping to identify and mitigate barriers to a safe discharge home and giving more time to emotional wellbeing than other professionals may be able to.

The health and social care system rely heavily on one another to work smoothly; however, the last 20 years have seen rhetoric about the failures of social care impacting on the NHS, and a

[3] Burrows, D. (2020) Critical Hospital Social Work Practice. London: Routledge
[4] Burrows, D. (2022) 'Social work for 'liquid old age': Some insights from an ethnographic study of a hospital social work team', Ethics and Social Welfare, 16(3): 258-273
[5] Heenan, D. (2023) 'Hospital social work and discharge planning for older people: Challenges of working in a clinical setting', Ageing and Society, 43(6): 1333- 1350
[6] Power, L., Dean, L., Evans, L., Haughton, A. & Holmström, C. (2023) 'Mystery and magic: Perceptions of social work within an acute hospital setting', Practice (Social Work in Action), 35(5): 405-423

focus on the financial cost of 'delayed' discharges from hospital, rather than the quality of the support given when a patient leaves hospital.

One member commented that too much focus is on throughput at the expense of limited research/understanding of the longer-term impact of not enabling people to stay longer in hospital. Whilst there is data available around health deterioration if stays are prolonged, there is limited data available on how social and emotional factors are improved through longer stays and improved assessments linked to time to undertake and implement a care plan.

Discharge to Assess models have been developed to tackle the financial and health costs of longer hospital admissions, by discharging patients as soon as possible. Discharge to Assess is a model of discharge planning that situates longer-term assessment and decision-making outside of the hospital, rather than discharge plans being made while the patient is still in hospital. This might mean a transfer directly from hospital to home, or to a residential step-down service where additional assessment and rehabilitation is offered, rather than a longer hospital stay. Initial findings from our research[7] into the effectiveness and acceptability of Discharge to Assess models suggest that they can have a positive impact by freeing up acute hospital beds, and that patients often prefer to recover in a less clinical setting or at home. However, inconsistencies in resourcing and integration of health and social care can undermine this impact by failing to provide the follow-on support that is required.

One member reported that Discharge to Assess was utilised as a quantitative measure for discharge, largely financial and the focus on 'organisational throughput' of patients reduced opportunities to assess the qualitative aspects of care required to ensure positive wellbeing and full recovery.

Another member highlighted a local pilot recently started in Ceredigion called, 'Discharge with Confidence[8]', a free (Welsh Government short-term funded), limited support service for up to a maximum of 2 weeks. This service focussed on alleviating some of the anxiety surrounding hospital discharge for those who may not have support waiting for them at home. Following referral, the coordinator would link the individual to a 'micro-enterprise', who would support them for up to 2 weeks and cover things like meeting them when they arrived home, making sure the heating is on, getting the shopping in, light cleaning, transport as well as support to seek advice and assistance through the local centre for independent living.

A recent challenge to both the NHS and social care has been the Covid-19 pandemic. At the height of infections, political and media focus in the UK was on 'saving the NHS', while social care and other vital services were not recognised in the same way. Government policy was updated frequently and communication between health and social care services was not always clear. Many social care staff, including social workers, were concerned not only about their own health, but also about the wellbeing of the people they were supporting. Use of Discharge to Assess models was accelerated and both the NHS and local authorities are now

[7] Offord, N., Harriman, P. & Downes, T. (2017) 'Discharge to assess: Transforming the discharge process for frail older people', Future Healthcare Journal, 4(1): 30-32

[8] Discharge with Confidence, Ceredigion County Council. Email lis.cooper@ceredigion.gov.uk

directed that Discharge to Assess should be the norm when an adult is well enough to leave hospital. BASW Cymru members report that following the Covid-19 pandemic, there has been a reduction in social workers positioned within hospitals which is significantly affecting their ability to undertake their role fully, to work in an integrated way and to ensure focus is consistently on the rights and needs of the person and their families/carers. Throughput has become the order of the day with little time given to ensuring continuity of wellbeing for the person and acknowledgement that there are real risks to preventing sufficient time for recovery and rehabilitation.

As one member commented:

'No one ever says, thank you for getting my loved one out of hospital so quickly'

The structure of hospital social work teams

As with elsewhere in the UK, hospital social work teams are more likely to be employed by the local authority than by the NHS in Wales, where there are 22 local authorities, 7 local health boards, 3 NHS Trusts and 2 special health authorities. There is limited information available to determine exactly how many dedicated hospital social work teams there are currently in Wales, and how they are configurated in terms of the ratio of qualified and non-social work qualified staff employed within them. However, in their 2023 Social Care Workforce Report, Social Care Wales presented data covering all social work teams in Wales, indicating a ratio of approximately 47% are social work qualified with around 34% being non-social work qualified. Non-social work qualified roles are occupied by staff who are typically very knowledgeable, experienced and skilled, however they do not hold the standard minimum qualification to register as a social worker; and they are paid less than qualified social work colleagues. The job titles for these roles vary greatly within and between local authorities and practice settings in Wales. To illustrate, a quick poll of 7 local authorities in Wales undertaken by BASW Cymru found the following: Adult services – Assessor care coordinator/manager, support worker, social care assistant. Children's services – childcare practitioners, childcare/child protection support assistants. This suggests that the non-social work qualified role is diverse and used in a variety of ways to support proportional assessment within social work teams.

It is generally understood that non-social work qualified roles do not carry the same level of statutory powers, duties and responsibilities as qualified social workers with respect to safeguarding and assessing risk. However, quantitative data from our surveys indicates non-social work qualified staff are not only engaged with assessments of eligibility for social care support, but also involved in complex or high-risk decision-making processes, such as assessing mental capacity, best interests and other safeguarding issues.

Ensure protected workspace for social work staff within the hospital.

Hospital social workers are not always based in the hospital they support. According to freedom of information replies within our research, at least 88% of local authority and 78% of NHS hospital social workers have access to office space within the hospital or other NHS

property. However, annotations to freedom of information replies, as well as interviews and survey responses, gave a more complex picture: e.g. hot-desking on a shelf in a hospital corridor.

Agile working is common, and a small number of participants described this as a positive factor allowing them to achieve a good work-life balance. However, finding space to work has significant limits on their ability to form good working relationships with clinical colleagues, and most importantly to spend time building rapport and gathering the information they needed from patients and families. Information sharing is vital when it comes to making good decisions about discharge and post-discharge care, but participants felt that gaining relevant information had become more difficult. In a time where the NHS is under pressure and ward staff are under pressure to discharge patients it is becoming increasingly difficult to ensure that information given is accurate to inform assessments and to ensure the best outcome for patients. Proximity to colleagues from different professions or different agencies can make a positive difference to multi-disciplinary working, allowing information to be shared more openly and more quickly, and physical distance can have the opposite effect. Frequent changes of staffing, such as when social workers are not allocated to work with a specific ward, can also negatively impact these working relationships by reducing familiarity between staff from different disciplines. It is therefore concerning that social workers have limited access to the hospitals they support.

Social work practice in hospital settings

Bridging gaps between health and social care, or between hospital and community have emerged as key identifiers of good hospital social work. Social workers spoke about acting as advocates for patients and families and about deploying knowledge about both the patient and their social setting to make robust discharge plans.

'No disrespect to therapists and health colleagues, but sometimes they're a bit blinkered, can't always see outside of a box with someone. You know, they see what the problem is, not what support could be in the community for that, rather than straight into a 24-hour care placement'

Social worker focus is on the people they support and facilitating individual choice and relationships as key factors in decision-making:

'[The daughter] was a trained carer, she was really sensible, she was really lovely, she doted on her mam so much, and she wanted to take her home… the ward staff just wanted me to just put her mam in a care home and I was like 'I don't think that's right, I think this daughter can really look after her mam'.

Through the consultation, our members spoke about prioritising the emotional consequences of the decisions they make and often felt that clinical colleagues prioritised physical wellbeing and risk over emotional wellbeing with limited awareness of the interplay between both states. Some also spoke about social workers having a role in understanding the patients' past and envisioning their possible future in a way that clinical staff do not have time to do. While

members could see the need for movement and through-put to free up space for future patients, social workers tended to prioritise the needs of the person in front of them.

A key role for social work in hospital discharge, is bridging gap with external care providers to secure packages of care. This requires excellent knowledge of a complex care system, enhanced communication skills and the ability to empower and facilitate changes for both providers and the person requiring care. Our members reported that they are consistently in positions where they are unable to secure the care required with the key reason being low pay of care workers combined with the negative image that surrounds care work. Our members noted that negative portrayals of care work combined with low pay and poor working conditions, are the key drivers in difficulties in securing appropriate care which is person centred. They reported that some care agencies are no longer recruiting and are now only delivering care and support within current resources and defined geographies. Whilst most social work assessments are undertaken in a timely manner, these difficulties result in significant delays which often leave social workers feeling accountable to the person and family. In addition, our members reported that there are specific needs which are becoming increasingly difficult to secure support: people at risk of falling, people who may have associated aggressive behaviour. Thus, those is highest levels of need are perceived as more complex and may have longer waits for care and support packages to be in place. One member commented that;

'Care homes insist on reassessing their existing residents before accepting them back after a hospital stay and often delay this assessment citing various reasons often related to their own staffing levels. Local authorities are reluctant to agree funding for enhanced packages of care and have internal decision-making panels that often delay discharges'.

This can result in substantial delays where decision making is not situated close to the person and with the named key worker. In addition, different discharge processes (e.g. Continuing Health Care (CHC), Best Interests Assessment) require different assessment protocols, which may also result in lengthy disputes, eligibility issues and rising costs, adding further delays and layers of bureaucracy.

In some instances, members reported that when these factors are combined, they can lead to unsafe discharges where bureaucracy and systems prohibit the voice of the person and their family being central to all decision making. Focus on the measurement of throughput, does not allow for individual's voice to be central. As one member commented:

'When people don't feel listened to, they feel hopeless. And when we get hopeless, then we get very poorly. Hope is about listening, and when we feel listened to, I feel valued and heard'.

In common with previous research, social workers also talked about their specialist legal knowledge, particularly around mental capacity. They often felt that clinical colleagues did not have enough understanding of mental capacity legislation and felt that it was their role to provide checks and balances against broad assumptions being made about patients' capacity to make decisions

'Clinical colleagues will say 'they don't have capacity' and you have to say 'capacity around what?' and we basically educate medical teams on what the [Mental] Capacity Act is, what it stands for, the legislation and we don't understand how that's still happening. Because it's been in since 2005, so how is that still happening now?'

In addition, our members raised some serious considerations in relation to hospital practices which have a clear legislative base. For example, DNAR (Do Not Attempt Resuscitation) orders are one of the most sensitive aspects of patient care. They require clear documentation, family discussions, and multidisciplinary input. The challenge is not just ensuring the form is completed but navigating the emotional and ethical dilemmas central to DNAR orders. Families often struggle with accepting DNAR decisions, particularly when they feel they are "giving up" on their loved one. DNAR orders should never be a standalone decision made purely by doctors. There is a critical need for holistic, person-centered discussions that involve palliative care specialists, social workers, mental health professionals, and the patient where possible. This ensures that the decision reflects the patient's values, beliefs, and quality of life considerations, rather than being a purely clinical judgment.

Advance Planning: The Need for Proactive Conversations. Advance planning is essential, yet it is often ignored or left too late. This leads to crisis decision-making, where patients and families are forced to make high-stakes choices under emotional distress. Advance planning should include:

• Early discussions about DNAR and end-of-life wishes when a patient is diagnosed with a progressive illness.

• Legal documentation, including Advance Directives and Lasting Power of Attorney (LPA), to ensure patient autonomy.

• Psychosocial support to help families navigate grief and decision-making.

Our members report that they have experienced many families left unprepared for sudden health declines. Without advance planning, conflict often arises, some family members may push for aggressive treatment, while others advocate for comfort care. This could be avoided if integrative planning was initiated earlier, ensuring the patient's voice remains central even when they can no longer communicate.

Integrative Practice should be an ideal and day to day working practice within the hospital discharge process. Hospital settings can be fragmented, with different professionals focusing on their specific domains, doctors on medical treatment, social workers on discharge planning, and therapists on rehabilitation. However, without integrative practice, patients and families often fall through the silos, receiving disjointed or contradictory information. Social workers, our members want to work in an integrated way, adopting integrative practice models which are based on:

• Interdisciplinary communication – ensuring doctors, nurses, social workers, and allied health professionals are aligned in their approach.

• Collaborative decision-making – particularly in cases of DNAR, palliative care, and end-of-life decisions.

• Holistic patient care – recognising that medical interventions alone do not define well-being; emotional, psychological, and spiritual needs are equally vital.

When integrative practice is absent, patients and families suffer confusion and distress, and professionals work in silos rather than as a cohesive team. An integrative care model enables trust and communication to be built and shared, cornerstones of professionals working together. Members report that the best patient outcomes occur when professionals actively share knowledge, perspectives, and resources rather than treating their roles as isolated tasks. It also assists in avoiding the over prescription of care which was frequently cited by BASW Cymru members.

Hospital stays have reinforced the critical importance of DNAR clarity, integrative practice, and advance planning. Healthcare should not be reactive but proactive, holistic, and collaborative. DNAR decisions should be made with compassion, integrative practice should be standard rather than optional, and advance planning should be normalised rather than feared. Ultimately, the goal is to respect patient autonomy, provide dignity in care, and reduce unnecessary distress for families and professionals alike.

A member reflected on their personal experience of supporting an older relative during hospital discharge where the assessment was carried out in English, which was not her first language Welsh, and also by a male Occupational Therapist. Due to the barriers with language, and in discussing personal matters with a male, the assessment was 'completely wrong'. Following a request for a re-assessment, a Welsh-speaking, female worker conducted the assessment, which was far more effective and resulted in a successful transition from hospital for the individual involved. This illustrates the importance of individuals being given the opportunity to be assessed in their chosen language and by the right person.

The changing nature of hospital discharge

There are indications that social work is being moved out of acute hospital settings. Within the BASW Uk research[9] explanatory notes appended to freedom of information responses indicted that Covid-19 restrictions were partially responsible for this change.

'When Covid restrictions came to force, the [NHS] asked the local authorities to move the social work staff out of the hospital. The staff have been relocated to strengthen the community social work teams and there is no intention to reintroduce the roles'.

Evidence suggests that where hospital social work teams have been withdrawn from hospitals, if they remain as a team, they are more likely to keep their identity and main role as the 'hospital social work team'.

[9] Social work in NHS hospitals: Opportunities and challenges | BASW

Some members who work on Discharge to Assess models, described the system as complex. One team described options for rehabilitation, short stay residential care, and settings described as more of a convalescent home, to recover from illness or injury but not necessarily to receive therapeutic input. All these options incurred different costs and might be self-funded by the patient or eligible for financial support from the NHS or local authority. The research[10] found that respondents were unsure about the value of Discharge to Assess models, with many respondents reporting that patients could be moved into residential care without proper consultation with the patient, family, or the local authority most likely to be responsible for the patient's ongoing care and support. Some participants could see the value of completing longer term assessments outside of the hospital setting, but none were unequivocally positive about the idea

Evaluations of Discharge to Assess models suggests that a lack of funding of community-based services for patients to access once they are discharged is one of the main barriers to effective implementation. There is also a risk that implementing Discharge to Assess models will simply move the problems of hospital discharge to a different setting. If community-based services and residential rehabilitation do not have the capacity to meet demand, and to provide holistic rehabilitation, then the health and social care system is likely to continue to experience delays, blockages and increased demand

Acknowledgements

With sincere thanks and appreciation to Carrie Phillips for her research in this area, and to all BASW Cymru members who gave their time to help improve care for people in or leaving hospital.

[10] Jeffery, S., Monkhouse, J., Bertini, L., Walker, S. & Sharp, R. (2023) 'Discharge to Assess: an evaluation of three case studies in the southeast of England to inform service improvement', BMJ Open Quality, 12: e002515

Carers Wales
Unit 5
Ynys Bridge Court
Cardiff CF15 9SS
info@carerswales.org

February 2025

Subject: The role of local authorities in supporting hospital discharges consultation

Dear Local Government and Housing Committee,

Carers Wales welcomes the opportunity to respond to this inquiry.

Carers Wales exists to make life better for the more than 310,000 unpaid carers across Wales. We are led by our 5,000 members in Wales, the vast majority of whom are unpaid carers, and together we provide support for and campaign with unpaid carers to secure lasting change. We are part of Carers UK and have been leading the way on carers' rights for 60 years.

A carer is a person of any age who provides unpaid care and support to a family member, friend or neighbour who is disabled, has an illness or long-term condition, or who needs extra help as they grow older.

Research shows that the care provided by unpaid carers saves the Welsh Government more than £10 billion over a 12-month period. The human impact of unpaid care is immeasurable. Carers hold families together, enabling the people they provide care for to get the most out of life while often making huge sacrifices to do so. Over 107,000 people in Wales provide over 50 hours of unpaid care every week.

- The effectiveness of local authorities in supporting hospital discharge amid the context of delayed transfers of care

The Social Services and Well-being (Wales) Act 2014 places a number of duties on local authorities, including to offer all unpaid carers an assessment of their needs in the form of a Carers Needs Assessment. This can lead to support to assist them with their caring tasks and support them to protect their own health and wellbeing alongside. Discharging someone from hospital so they can be looked after at home requires an assessment of the unpaid carers needs so support can be put in place to enable the carer to look after the person being discharged. Unfortunately, there is extensive evidence to suggest that vast majority of unpaid carers are not having their needs assessed. The 2024 report of the Ombudsman Wales found that in the four investigated local authorities just 2.8% of unpaid carers had undergone a Carers Needs Assessment. The Track the Act 2024 report, published by Carers Wales, suggested that between just 0.3% and 0.8% of unpaid carers across Wales received a Carers Needs Assessment in 2023/24. In addition to the vast majority of carers missing out on assessment of their needs, 63% of carers in the same survey who had tried to obtain support from social care services had experienced long wait times for assessments, reviews or support. The Ombudsman found that just 1.5% of the carer population of the investigated authorities had an assessment that led to a support plan.

Carers Wales
Unit 5
Ynys Bridge Court
Cardiff CF15 9SS
info@carerswales.org

This concerning picture demonstrates that serious questions must be asked about the effectiveness of local authorities in facilitating hospital discharge by supporting families to look after patients discharged from hospital.

Unpaid carer testimony – Carers Wales State of Caring in Wales 2024: The impact of caring on health and wellbeing report

> *"Applied for carers assessment in January this year (2024), still awaiting reply (August 2024)."*
>
> *"I managed to access a care and needs assessment - referral from specialist children's services. The social worker came in January 2024 - I have yet to hear back (August 2024)….completely pointless exercise."*

- The main barriers for local authorities in effectively facilitating the discharge of patients with care and support needs, including:
    - social care capacity and workforce shortages;
    - waits for care assessments (and other assessment related issues),
    - challenges in arranging care home placements or home care packages, and
    - disagreements or legislative barriers affecting discharge decisions;

As detailed above, it is clear that effective and sustainable hospital discharge is inhibited as far too few unpaid carers are having their needs assessed and far too many are experiencing long waits to have an assessment or receive the support they need to carry out care tasks. This undermines the principle that stays in residential care following hospital discharge, if they are needed at all, should only be temporary while support is arranged for the person to be looked after in their home. Without support for carers, patients will stay in residential care longer than they need to.

There are widely acknowledged challenges in procuring sufficient home care packages for patients being discharged from hospital across the UK. In response, local authorities should offer fast-tracked direct payments to enable the patient and their family to quickly purchase the support they need. The 2022 report of Audit Wales into the use of direct payments in social services found that greater clarity was needed on what direct payments can be used for, and we would urge local authorities to embed flexibility into the use of direct payments so families can use the funds in the ways that meets their own needs and preferences. Local authorities also have an important role to play in providing guidance and support to enable families to use direct payments. As the Health and Social Care (Wales) Bill will extend the option of direct payments to recipients of NHS Continuing Healthcare, we must take this opportunity to improve the direct payments system by co-producing the regulations as well as the information and guidance given to patients, carers and professionals.

Carers and families can feel like their needs and preferences are sidelined during disputes between which part of the public sector is responsible for providing them with support. This is particularly seen when there are disputes between health boards and social services regarding whether the patients' needs are primarily the responsibility of health or social services. The needs of carers and patients

Carers Wales
Unit 5
Ynys Bridge Court
Cardiff CF15 9SS
info@carerswales.org

cannot be sidelined during disputes over different pots of public money. Local authorities and health boards should explore pooled budgets to facilitate smoother transitions between health and social services settings. Regional Partnership Boards have the potential to assist with facilitating this.

- The variations in hospital discharge practices throughout Wales and the impact on local authority delivery. How to improve consistency, including the identification of best practice and innovative approaches that could be adopted more widely;

Under the Social Services and Well-being (Wales) Act 2014 unpaid carers have a right to have their needs and preferences meaningfully considered by professionals who must ascertain whether a carer is "able and willing" to provide care, including which caring tasks they are willing and able to undertake. Concerningly, in our State of Caring in Wales 2024 survey, only 27% of carers who care for someone who had been discharged from hospital in the previous 12 months agreed that they had been involved in decisions about discharge and what care and treatment was needed. Additionally, our 2024 Track the Act report found only 12% of people with caring responsibilities were identified as carers within medical settings. The understandable desire on the part of health boards to free up beds risks creating situations where carers feel under pressure to agree to undertake caring tasks they do not actually feel able to carry out. Sustained and meaningful consultation with carers is the only way to accurately understand the level and types of care the carer will be able to provide for the patient. A failure to identify and consult with carers risks an unsustainable hospital discharge with the carer unable to cope under unrealistic expectations.

Unpaid carer testimony – Carers Wales State of Caring in Wales 2024: The impact of caring on health and wellbeing report

> *"I was ignored by most staff during my mother's stay in hospital, despite me raising concerns. No help was offered at all on her return home, I was just expected to "get on with it"."*
>
> "*Stress, guilt and anger - if I had a pound for the number of times I've heard a phrase like 'can't your daughter do that for you' I'd be able to afford a decent care home!*"
>
> "*My dad was discharged from hospital on a Saturday afternoon with 1 hrs notice. He was doubly incontinent at that time and was discharged wearing a pad, but with no others given to take home. He was also extremely confused and could not do much for himself (e.g couldn't get washed or dressed, manage the toilet, make a bowl of cereal) I was given no advice or support, and no information about who to contact if there were any problems. No services were open until Monday morning for any help. He had not previously required care so nothing was in place at home.*"

There must be clear expectations on staff in hospital settings to identify and meaningfully consult with carers. Staff training also plays a role, such as the training provided through the Carer Aware project delivered by Carers Trust Wales and Carers Wales. Local authorities must also substantially improve their delivery of Carers Needs Assessments so the needs and preferences of carers can be effectively understood. In 2021/22 and 2022/23, £1m was allocated to health boards by the Welsh Government to

Carers Wales
Unit 5
Ynys Bridge Court
Cardiff CF15 9SS
info@carerswales.org

improve engagement with carers during hospital discharge. Consideration should be given to allocating similar funding potentially shared between local authorities and health boards to facilitate smoother and more sustainable hospital discharge.

Unpaid carer testimony – Carers Wales State of Caring in Wales 2024: The impact of caring on health and wellbeing report

> *"They keep passing us to other services who keep passing us back to them. Still don't have the support we need."*
>
> *"I am being passed between adult social care, learning disabilities social care, home from hospital care. No one can actually help."*

The Ministerial Advisory Group on Carers has discussed good practice at length and, while it is valuable to identify good practice, we must ensure we prioritise translating that good practice into tangible delivery at pace, accompanied by additional funding and resource.

- An assessment of current discharge processes and procedures at a local government and national level, including partnership working between the NHS and local authorities, strategies for increasing community capacity, and the effectiveness of Welsh Government support.

Around 140,000 people in Wales combine unpaid caring responsibilities with some form of paid work. In the State of Caring survey 49% of carers who had experienced challenges with social care services said it negatively impacted their ability to work. Carers are already more likely to live in poverty as a result of caring and this situations risks more carers falling into poverty as they are forced to reduce their hours or give up work entirely and also undermines wider policy aspirations for economic growth.

As far back as 2019 the Senedd Health and Social Care committee's report into carers rights under the 2014 Act, said *"Given the lack of impact of the legislation to date and the scale of the future challenge, we believe that the Welsh Government needs to demonstrate stronger national leadership in support for carers"* with the committee recommending that the Welsh Government *"must prepare, within 6 months, a clear action plan for addressing the failings of implementation highlighted in the evidence we received"*. The Social Services and Well-being Act was a forward-thinking piece of legislation that provides a valuable, comprehensive framework for how unpaid carers should be supported. Unfortunately, as demonstrated by the 2024 Ombudsman report, the 2024 Track the Act report, the 2024 State of Caring in Wales report as well as the findings of the Welsh Government-commissioned independent evaluation of the Act published in March 2023, sufficient action has not been taken in the years since the 2019 inquiry to address the implementation issues. Welsh Government must demonstrate stronger national leadership in relation to the Act and should set clear expectations of health boards and local authorities to ensure carers rights are more consistently upheld.

Unpaid carers save Wales billions of pounds every year and play an integral role in the health and social care system. Their role in hospital discharge is immense, so it was regrettable that the Welsh Government's initial and subsequent statements regarding their recent 50-day challenge to improve hospital discharge and community care did not mention the vital role of unpaid carers. Health boards,

Carers Wales

Unit 5
Ynys Bridge Court
Cardiff CF15 9SS

info@carerswales.org

local authorities and the Welsh Government must ensure all initiatives and policies relating to hospital discharge recognise the central role of the hundreds of thousands of unpaid carers across Wales who can, when adequately supported, enable people to be discharged from hospital. With much-needed additional funding for health and social care announced in the Welsh Government's budget for 2025/26, we must ensure that additional funding is allocated by decision makers at all levels to increase support for unpaid carers before, during and after the person they look after is being discharged from hospital. Doing so would be an investment in sustainable and effective hospital discharge.

There is additionally a pressing need to support the health not just of the person being discharged but of the unpaid carer themselves. Providing unpaid care sadly comes at great cost to the health of many carers. Public Health Wales has found that unpaid carers have higher rates of 36 long term health conditions compared to the population without caring responsibilities. In our 2023 State of Caring survey, half of carers said they had put off their own health treatments because of the pressures of their caring role and this year 82% of carers said the impact of caring on their physical and mental health would be a challenge over the coming year. Insufficient support for unpaid carers risks their ability to look after their loved ones discharged from hospital but it also raises the prospect of the carer requiring medical intervention in their own right and potentially being hospitalised themselves due to the health impacts of caring.

Unpaid carer testimony – Carers Wales State of Caring in Wales 2024: The impact of caring on health and wellbeing report

> *"I struggle to maintain my own health. I also have trouble picking up medications from the GP and there doesn't seem to be any help with this. I also think GP practices don't understand how hard it can be for carers to make an appointment at all and wish this was recognised and we could be more supported in this - for example I can only make appointments on the 1 day a week that I'm not with my child."*
>
> *"My physical health is declining due to lifting my 8 year old daughter all the time. Occ Therapy team/social services are too slow to provide support."*

Yours faithfully,

Jake Smith

Senior Policy and Public Affairs Officer

Carers Wales

YMDDIRIEDOLAETH GOFALWYR CYMRU | CARERS TRUST WALES

The role of local authorities in supporting hospital discharge

Response to the Senedd Local Government and Housing Committee inquiry

February 2025

Carers Trust

Carers Trust works to transform the lives of unpaid carers. It partners with its network of local carer organisations (ten in Wales) to provide funding and support, deliver innovative and evidence-based programmes and raise awareness and influence policy.

Carers Trust's vision is that unpaid carers are heard and valued, with access to support, advice and resources to enable them to live fulfilled lives.

Context: Unpaid carer support through hospital discharge
The point of discharge of a patient from hospital is often when many people become unpaid carers for the first time, or when their caring responsibilities become greater or more intense. Following the patient's discharge from hospital, unpaid carers need support in the community to ensure both the cared-for person has access to appropriate social care support, and that they as unpaid carers have the support they need to sustain them in their caring role. As such, the integrated working between local carer organisations, local authorities and health boards is an essential component of effective hospital discharge.

Legislative context
People who are caring, or intending to care for someone, including those who are supporting someone being discharged from hospital, have rights under the Social Services and Wellbeing (Wales) Act 2014.

The Social Services and Wellbeing (Wales) Act 2014 (the Act) places legal duties on local authorities to uphold the rights of unpaid carers. Recent secondary legislation

to strengthen partnership arrangements under the Act now mean that health boards, via Regional Partnership Boards, are more strongly implicated under the Act's duties and are required to work in partnership with local authorities to deliver the Act's intentions.

Under the Act, unpaid carers have the right to:

- Access information, advice and assistance
- Be assessed if it appears they have a need for support, and to have all eligible needs met through a local authority support plan

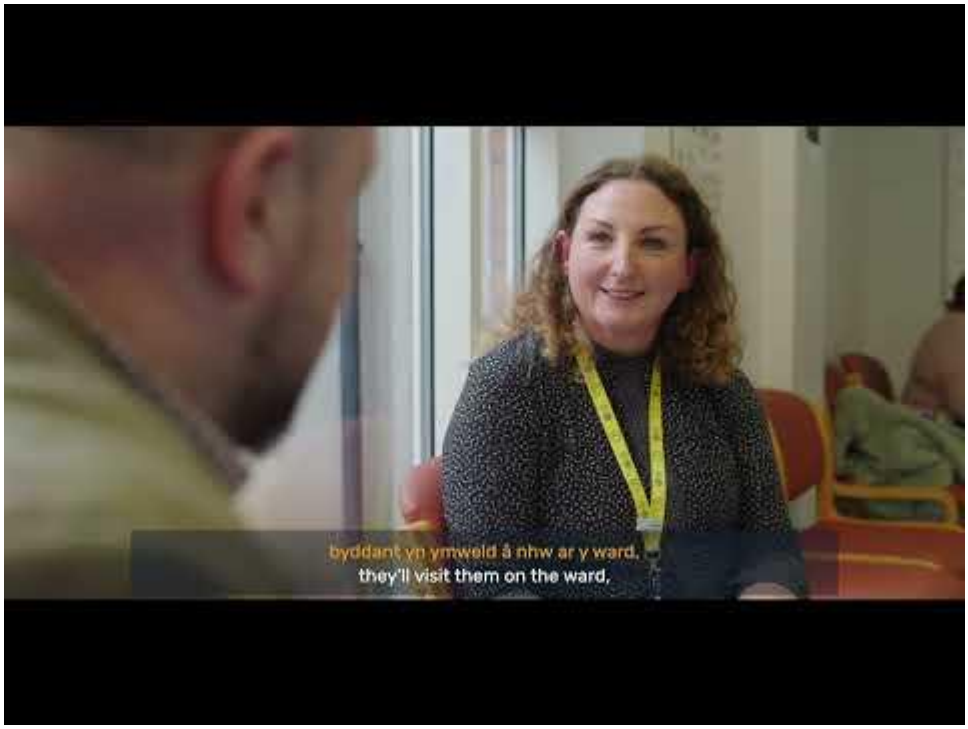
The Act is clear that a person must be "willing and able" to provide care. The extent to which a carer is able to provide care and willing to do so is assessed as part of the formal statutory Carer's Needs Assessment undertaken by the local authority, including when they have been identified within a health setting at the point of discharge from hospital.

Integrated working between local carer organisations, health boards and local authorities

Local carer organisations across Wales are commissioned by statutory partners – primarily health boards or Regional Partnership Boards – to deliver services that support unpaid carers who are caring for someone who has been admitted to, and subsequently discharged from, hospital. These are predominantly funded through by Regional Partnership Boards through the Regional Integration Fund or through the allocation of annual funding to health boards from Welsh Government (this has been to the total value of £1m across all seven health board areas for the past decade). In recent years, this funding has had an explicit focus on facilitating support for unpaid carers through hospital discharge.

Several of the local carer organisations that are part of the Carers Trust's network in Wales are commissioned to deliver Hospital Facilitators or Hospital Discharge Support services in this way. While these services vary locally, they all aim to improve the identification of, and support for, unpaid carers who are caring for someone in hospital. This is with the view that support for the unpaid carer will improve patient flow through the system by facilitating better, safer and more sustainable discharge of the patient.

Support from local carer organisations includes attendance at Multi-disciplinary team meetings, working with Discharge Nurses, Hospital Social workers, referral to social services for a Carer's Needs Assessment and facilitating communication with the carer. Unpaid carers say the impact of the service is invaluable to them. As part of the Welsh Government funded Carer Aware programme, this short film captures elements of the integrated working between local carer organisations in Swansea Bay UHB and Betsi Cadwaladr UHB:



Carer's Needs Assessments
Local carer organisations' Hospital Facilitator Services will often provide support for the carer within the hospital and help to arrange the support the carer may need once the patient is discharged into the community. This commonly includes a referral to the local authority for a Carer's Needs Assessment, in line with the unpaid carer's rights under the Social Services and Wellbeing (Wales) Act 2014.

It is acknowledged nationally that there are considerable waiting times for Carer's Needs Assessments. The ADSS Cymru Rapid review of unpaid carers' rights summarised its findings thus in relation to Carer's Needs Assessments across the country, based on research undertaken in 2023:

> "There are waiting lists for carer's assessments in most areas, which prevents carers having the support they need. Many carers are not being offered assessments."

A Task and Finish Group has been established by the Welsh Government Ministerial Advisory Group on Unpaid Carers to respond to this report's recommendations. While this work is underway, unpaid carers may continue to face delays in accessing statutory assessments to meet their needs.

In some areas of Wales, local carer organisations are commissioned to undertake Carer's Needs Assessments on behalf of the local authority, particularly with a view to bringing down existing waiting lists for assessment. In some instances, the same local carer organisation provides a hospital facilitator service for the health board and is commissioned by the local authority to undertake Carer's Needs Assessments. This has the double benefit of ensuring that carers in the area have consistent support at a time when they may be particularly vulnerable and minimises the number of agencies unpaid carers are referred to.

While the commissioning out of Carer's Needs Assessments to local carer organisations often leads to a more meaningful conversation about 'what matters' in the assessment with carers, local carer organisations report that the funding allocated to them is not always sufficient to resource meaningful assessments. As a result, some local carer organisations will no longer take on contracts for Carer's Needs Assessments from the local authority where the contract value does not reflect the true cost of service delivery. In line with recent guidance through the National Commissioning Framework, local authorities must work to understand an appropriate formula for costing the undertaking of Carer's Needs Assessments if these are to be meaningful exercises for unpaid carers that lead to appropriate support.

Community capacity

Sustainable discharge services rely on the existence of community services infrastructure to provide wrap around support needed by unpaid carers and the cared for person on their return to home. Preventative community services should include specialist unpaid carer support as part of a Multi-disciplinary team that offers home aids and adaptations, advocacy, social work and reablement. This preventative service is an essential component of maintaining safe discharges and should be funded consistently, by local authorities or Regional Partnership Boards, as part of their statutory duties under the Act.

National resources and guidance

The ADSS Cymru review also concluded that:

> "While the Act relates to social services, identifying unpaid carers is not their responsibility alone. GP surgeries and other health services, including hospitals, should play a much bigger role as part of a more integrated health and social care system."

As part of the Carer Aware programme, funded by Welsh Government and delivered in partnership between Carers Trust Wales and Carers Wales, a series of resources

to support unpaid carers through the hospital discharge process have been produced to support the health and care workforce:

- Policy guide for NHS service planners and managers
- Practical guide for health care professionals
- Good practice principles for Social Workers (section on hospital discharge)

These resources, coproduced with health and social care professionals, local carer organisations and unpaid carers from across all areas of Wales provide a framework for consistency of approach across the country. Working within Regional Partnership Board structures and in meeting their statutory duties under the Act, local authorities should make use of these resources to support service planning at a strategic level and to support staff training and development.

Further information

Dr Catrin Edwards, Head of External Affairs, cedwards@carers.org

Additional information from the Welsh Local Government Association on the inquiry into housing support for vulnerable people

Please see below further information, as requested, following the evidence session on 6th March: -

- **Information about how much data local authorities hold on the extent of support need in their local area, and how that data is used to inform commissioning (363-364)**

In accordance with the terms and conditions of accepting the Housing Support Grant, it is a mandatory requirement that all Local Authorities in Wales undertake a Strategic Needs Assessment, which in turn underpins the Housing Support Programme Strategy at 4 yearly intervals, with a light touch review of the needs assessment completed mid-term.

The needs information used for the strategy and development plans by Councils typically includes: -

- **Profile of the borough**: Assessments of local wellbeing information, including population and age bandings, Welsh language, gender, ethnicity, national identity, and reference to the armed forces population
- **Food bank usage**: Information around the usage of food banks.
- **Economic and workforce data**: Including working population and earnings.
- **Education information**: Data on pupils, schools, and free school meals.
- **Health information**: Such as births, deaths, general health, and mental health.
- **Housing and Homeless information**: Including WIMD (Welsh Index of Multiple Deprivation), housing stock, tenure, accommodation types, and occupancy rates, deprivation figures, housing market statistics, new build and temporary accommodation data.

Further information used to inform commissioning decisions typically includes existing service data, the financial contributions currently paid, and any information about future budget availability or pressures on the existing value.

- **Whether there is any evidence of local authorities refraining from retendering some services due to increasing costs or capacity (paragraphs 377-378)**

The responses we have received from authorities do not provide any evidence that local authorities are refraining from tendering. However, capacity constraints within Council's commissioning teams have been highlighted by a number of authorities, and the majority reported significant increases in costs from providers. The recent increases in the HSG budget allocations have been identified as critical in allowing commissioners to respond to these cost pressures in order to maintain services.

- **Details of which local authorities are not yet delivering Housing First projects and whether any others are considering rolling back on theirs (paragraphs 416-417)**

WLGA does not hold the definitive information on which local authorities are not yet delivering Housing First projects. However, from the responses received from authorities, none have indicated that they are currently considering rolling back their provision.

Agenda Item 8

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