Agenda - Local Government and Housing Committee

Meeting Venue:	For further information contact:
Committee Room 2, Senedd	**Manon George**
Meeting date: 27 March 2025	Committee Clerk
Meeting time: 09.15	0300 200 6565
	SeneddHousing@senedd.wales

Remote

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 1

09.15 - 10.15 (Pages 1 - 72)

Professor John Bolton

Professor Jon Glasby

Attached Documents:

Research brief

Paper 1: The role of local authorities in supporting hospital discharges - written evidence from Professor Jon Glasby

Paper 2: The role of local authorities in supporting hospital discharges - written evidence from Professor John Bolton

Break

10.15 - 10.25

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

10.25 – 11.35 (Pages 73 – 107)

Councillor Charlie McCoubrey, Leader of Conwy County Borough Council and Welsh Local Government Association Spokesperson for Health and Social Care

Councillor Jane Gebbie, Deputy Leader and Cabinet Member for Social Services, Health and Wellbeing, Bridgend County Borough Council and Welsh Local Government Association Spokesperson for Health and Social Care

Councillor Mary Ann Brocklesby, Leader of Monmouthshire County Council

Lance Carver, Chair of ADSS Cymru and Director of Social Services, Vale of Glamorgan County Council

Jason Bennett, Chair of All Wales Adult Service Heads and Head of Adult Social Care and Vale Alliance, Vale of Glamorgan County Council

David Soley, Principal Manager, Lead Commissioner of Denbighshire County Council

Attached Documents:

Paper 3: The role of local authorities in supporting hospital discharges – written evidence from the Welsh Local Government Association

Paper 4: The role of local authorities in supporting hospital discharges – written evidence from The Association of Directors of Social Services Cymru

Break

11.35 – 11.45

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

11.45 – 12.45 (Pages 108 – 116)

Jennifer Winslade, Director of Nursing, Aneurin Bevan University Health Board

Gethin Hughes, Chief Operating Officer, Cwm Taf Morgannwg University Health Board

Cath Doman, Director of Health and Social Care Integration, Cardiff and Vale Regional Partnership Board.

Attached Documents:

Paper 5: The role of local authorities in supporting hospital discharges – written evidence from the Welsh NHS Confederation

5 Papers to note

12.45

5.1 Forward work programme

(Page 117)

Attached Documents:

Paper 6: Forward work programme – Letter from the Public Accounts and Public Administration Committee

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

12.45

Private meeting

12.45 – 13.00

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

12.45 – 13.00

By virtue of paragraph(s) vi of Standing Order 17.42

Agenda Item 2

Document is Restricted

Papur 1 / Paper 1

Hospital discharge

Discussion material

Prepared by Jon Glasby (November 2023)

IMPACT Improving Adult Care Together

The Health Foundation

UKRI Economic and Social Research Council

How you can use this discussion material

This discussion material is based on evidence from research, lived experience and practice knowledge. You can use it to reflect on your current services and to open up conversations with people, families, colleagues and partners about ways to make evidence-informed changes to what you do.

This discussion material is about hospital discharge for older adults. In particular, it suggests that lots of the key themes have been the same over time (in different nations of the UK and in different policy contexts). In many ways, hospital discharge is a key ‘fault line’ on the boundary between health and social, with competing notions of what constitutes good practice and different definitions of success. For older people stuck in hospital it can be incredibly frustrating. However, there is also a risk of premature discharge or poorly co-ordinated discharge – which can be just as damaging. Ultimately, we might make more progress if we saw things through the eyes of the older person, focused on delivering what matters to them; found ways to go beyond the boundaries of our own professional/organisational role; and recognised that the problematic nature of hospital discharge is nobody’s fault – just a product of the way our system is designed.

What is the issue?

Hospital discharge is a really difficult area of policy and practice for a range of reasons (see below for further discussion) – but it tends to hit the headlines because of the impact it has on the health service, rather than the impact it has on older people and families. In practice, both are important – but we need to make sure that we’re focusing on outcomes that matter to people and that we don’t only see adult social care through the lens of the NHS.

Before exploring these issues further, it is important to be clear on key terms – which are very contested (see Box 1). In practice, anything we can do, individually and collectively, to avoid the term ‘bed blocking’ is basically a step in the right direction.

We also need to recognise that this is an international issue (affecting lots of different health and social care systems around the world). As but one example, a review of good practice in trying to tackle these issues found relevant studies from different parts of the UK, the US, Australia, New Zealand, Italy, Lebanon, Singapore, the Netherlands, Pakistan and India (Cadel et al., 2021).

These are also very longstanding issues (see Glasby, 2003 for some of this history). In the UK, for example, the first government guidance on this issue was published in 1963, and concerns about people becoming delayed go back to the very beginning of the NHS (and even further back). Thus, during the Second World War, there were concerns that the rest centres set up to support people whose houses had been damaged by the bombing would become ‘blocked’ by frail older people who came into the service due to an emergency housing need, but who might be unable to leave due to ongoing health and social care needs (the so-called ‘un-billetables’).

Box 1: The importance of terminology

Historically, people have talked about this in terms of **'bed blocking'** (with people stuck in hospital described as **'bed blockers'**). This is still the case in the media – and sometimes from a health professional – but most people see this as an offensive and unhelpful term, effectively blaming the victim (i.e. as if it's the person's fault they are still in a bed – when they're almost certainly desperate to get home and only there because the system can't organise itself to get the person out).

A more neutral term is **'hospital discharge'** or **'delayed discharges'** (used here). However, the use of the word 'discharge' runs the risk of encouraging hospital services to see their role as finished when the person leaves (i.e. their responsibilities end when they 'discharge' the person from their care, rather than playing an active part in a planned transition from one setting to another, with responsibilities to achieve a smooth transition shared).

Probably most accurate, therefore, is the term 'delayed transfer of care' – which captures this sense of a transfer rather than one set of responsibilities abruptly ending. However, it tends not to slip off the tongue, and policy tends to abbreviate it to 'DTOCS' (which sounds horrible and impenetrable).

The impact on health services (and often the media and policy focus)

Current policy and practice is very focused on tackling the huge backlogs which built up in the NHS during COVID – and freeing up beds by tackling delayed transfers of care is a key part of getting the waiting list back under control. Hospital beds are an expensive and (compared to a number of other health systems internationally) scarce resource, for which demand frequently outstrips supply. There is therefore significant pressure on health service colleagues to ensure rapid throughput – and delays in people leaving hospital when they no longer need the services provided there are a major source of frustration.

This has sometimes been likened to the motorway on a bank holiday, when there is just too much traffic for our road network to cope. It only needs a minor change – too many cars joining at a junction, a piece of debris on the road, a really minor shunt, some minor roadworks – and the whole thing can ground to a halt.

Another parallel is a bath filled to the brim. If even a small glass of water is poured in, the entire contents of the glass spills out onto the floor, because there is literally nowhere else for it to go.

However, there is a danger that pressures on the health service come to dominate other priorities – and that we end up interpreting what social care does through the eyes of the impact it has on health partners, rather than valuing the contribution it makes in its own right. Certainly this is a risk in the media and in some policy circles. Just to put this in context, about half the adult social care budget is spent on people of working age (not on older people at all), and supporting discharge from hospital represents a fairly small amount of what adult social care does at any one time.

Moreover, although waiting for various forms of social care can lead to significant delays (and the number of social care-related delays has been increasing) – it often accounts for less than half of delays. Prior to the pandemic, for example, social care accounted for about 40% of delays (either social care delays or joint health and social care delays). While significant, the NHS was solely responsible for the other 60% (Cavallaro et al., 2023).

The impact on older people and families

While delays leaving hospital have a significant impact on the NHS, they are also problematic for patients and families. Hospitals are busy, stressful environments, and most people want to get home as quickly as they can. Staying for longer than you need can also put you at risk of a hospital-acquired infection, and being in bed all day can reduce people's independence and functional ability. People with learning disabilities or with dementia might also find hospital really confusing and disorientating, making it even harder to keep independent.

Beyond the issue of delays, moreover, there is a longstanding literature on hospital discharge, with common themes emerging time and again over decades (at least as far back as research in the 1960s and 1970s – see Glasby, 2003 for a summary). These include:

- Poor communication between hospital and community
- Poor planning in situations where people are likely to have ongoing needs after they leave hospital
- Inadequate notice of discharge
- Inadequate engagement and consultation with patients and their carers
- Over-reliance on unpaid carers at the point of discharge (when someone might have particularly significant needs) and lack of (or slow) statutory service provision
- Inattention to the needs of groups who might need even more support (such as people with dementia, homeless people)

What stands out from this literature – particularly from studies which have talked to older people and to families – is how distressing it can be to be on the receiving end of all this (see Box 2 for some practical examples from Age UK's advice line). People describe being at their wits end and feeling completely helpless, with no ability to influence what happens to them, and with families feeling completely taken for granted and left without adequate support. This latter issue was brilliantly but heart-breakingly captured over 20 years ago by IMPACT's Emily Holzhausen in the title a national report for Carers UK: 'You can take him home now.'

Box 2: Negative experiences of hospital discharge (case studies from the Age UK [2016] helpline)

Mary: Paul's wife Mary, 85 years old, is in hospital. She has lost her mobility during her hospital stay. Yesterday the hospital told him Mary was ready for discharge today and she can't occupy a hospital bed anymore. Nobody has assessed what she will need to help her recover at home, whether she can regain her mobility, or what adaptations are available to help them manage. Paul was able to delay the discharge for a day by getting the Patient Advice and Liaison Service involved but he still wasn't given any information about her rights, or about how they are going to manage at home.

Phil: Phil is in hospital and nearing the end of his life. The hospital says they can't do any more for him and want to discharge him. Phil lived in a care home with nursing prior to going into hospital, but this home is now unsuitable. Social services have identified a couple of alternative care homes, but his daughter Susan and her family have refused them because they are too far away for the family to visit him regularly.

The family have found what they consider to be a suitable home nearer to them but there aren't any vacancies. They've asked the GP to refer Phil to a hospice, but the GP has refused because Phil's diagnosis doesn't say he has a specified time to live.

Alfred: Alfred is in hospital following a series of strokes and is due to be discharged in the next two weeks. It is being recommended that Alfred now goes to a care home. Alfred lacks mental capacity to make decisions about his care arrangements but his son has a registered Enduring Power of Attorney for Alfred's property and financial affairs. The hospital social worker is advising the family that social services will choose the care home and that it will need to be some way away to meet local authority cost limits. The family is unhappy about this because they think he needs to be closer to them so they can visit regularly.

Bob: Hannah's father Bob has a range of health problems, including dementia. At a discharge planning meeting two weeks ago the consensus was that Bob should return to his sheltered accommodation unit with a care package in place. However, the housing association that manages the sheltered accommodation says they do not want him to return because he is no longer well enough to manage, while Social Services are saying that sheltered housing is his best option at the moment as he does not yet meet the criteria for specialist residential dementia care. Hannah feels that they are now at an impasse and that she is going to be forced to agree to something she doesn't believe to be the best option for Bob.

Rachel: Janet's mother Rachel is in hospital for the second time in 10 days. Rachel lives in her own home. Janet feels she shouldn't have been discharged home on the first occasion and intends to complain. Before her readmission the Intermediate Care Team agreed that she wasn't safe at home. Now that Rachel is back in hospital Janet fears the same thing will happen again. She's trying to find someone who can help them find out what the options are and wonders what the responsibilities of the hospital social worker are and who, if anyone, joins everything up.

Putting these issues into a broader context

Taking a step back, therefore, some of the biggest issues aren't about delays in isolation. Instead, there are a series of broader challenges and dilemmas:

- While there is significant focus on delayed discharges, there can be just as much of an issue with premature discharge (when someone feels pressured to leave hospital before they feel ready to be back in the community) and/or poorly co-ordinated discharge (where all the focus is on getting the person out of hospital, not on enabling a smooth transfer to community services).
- When pressures increase on hospitals, there can be pressure to get people out at almost any cost – and this can lead to premature admissions to care homes, rather than taking the time to help people return to their own homes. Even if a care home placement is intended to be short-term, the risk is that under-staffing and lack of access to rehabilitation can turn a short-term admission into a permanent one, prematurely 'writing people off' as unable to be at home. Lots of people would argue that no one should be admitted straight to a care home from hospital, unless they were living in a care home before they were admitted (a 'home first' approach).

- Hospital is a really bad place to make fundamental, long-term decisions. You might be scared, in pain, disorientated – and just not yourself. Wherever possible, people are usually desperate to get home, so that they can take stock, start to recover and get support to be the best that they can be, before taking any longer-term decisions about their care and support.
- Various policy initiatives have tried to create new services that people can go to for additional support and rehabilitation after hospital. However, if an underlying issue is that there isn't enough capacity in the system, then these services can quickly fill up, becoming just as 'blocked' as the hospital beds they were designing to free up. There are some fantastic services that provide really tailored care and support, build people's confidence and help them return home – but there's also a danger that we just shift a problem somewhere else, so that it's 'out of sight and out of mind'. The risk of this usually increases when we do something under significant pressure/quickly, when we don't consult partners first and, above all, when we don't engage with older people and families to design services.
- While all the policy focus tends to be on discharging people from hospital, it's just as important to work in a more preventive way to help people stay as healthy and independent as possible, thus reducing the number of people admitted to hospital in the first place. Indeed, a former national body (the Audit Commission) helpfully identified a 'vicious cycle' where there is insufficient prevention and rehabilitation, leading to too many people being admitted to hospital and discharged to permanent care homes places, meaning there is even less money available to spend on prevention/rehabilitation – thus leading to even more hospital admissions and discharges to care homes. Instead, they proposed investing strategically in prevention and rehabilitation as a way of breaking out of this vicious cycle.

Some important gaps in our knowledge

Although these issues have been widely debated and frequently researched over the years, there are still a number of key gaps in our knowledge – both of which are important for this IMPACT Network to take into account:

1. Most previous research into the extent of delays has tended to be conducted by medical/clinical researchers, reviewing the case notes of patients in hospital (either based on professional opinion or using a structured tool to decide who is delayed in hospital and who still needs to be there). However, there have been surprisingly few meaningful attempts to involve older people, families and front-line social staff in this research and these debates. The risk here is that any solutions put forward may fail to draw sufficiently on this lived experience and practice knowledge, thereby failing to solve the issues at stake. In contrast, IMPACT argues that people are experts in their own experience, they often know what works for them and they are the only people who have an overview of their journey through services (with many of the professionals involved in their care and support often only knowing them at a particular moment in time) (Glasby et al., 2004a-b, 2006; see also Glasby et al., 2016 for a similar discussion around debates about 'inappropriate'/preventable admissions to hospital).

2. Some research is so focused on counting delays and on identifying risk factors and characteristics of patients who experience delays, that it fails to consider possible solutions. To counter this, an international review by Cadel et al (2021) looks at international good practice examples, in an attempt to be more solutions-focused (see Box 3). However, numerous problems remain – not least the facts that most studies are focused on quantitative outcomes rather than the perspectives of patients, families and staff; that sustainability of new initiatives is rarely considered; and there is a lot of contextual information missing from accounts of perceived good practice.

What needs to happen next?

In one sense, there are no real solutions – as suggested earlier, this has been an issue since before the NHS came into existence, in all four nations of the UK and in lots of different countries around the world. Although often associated with older people (which is the focus here), it's also an issue for other groups of people, including people with learning disabilities (Ince *et al*., 2022) and people with mental health problems (see, for example, Glasby and Lester, 2004; Poole *et al*., 2014). One of the reasons why no one has solved this issue is that it involves competing notions of good practice. Although it is a vast oversimplification, hospitals tend to be focused on/rewarded for efficiency and 'throughout' (getting someone in, treating them, getting them out again and using the bed for someone else), while social care tends to be focused on empowerment (looking at outcomes that matter to the person, and helping them make very difficult and potentially life-changing decisions about their long-term destination and needs). It's not that one of these is right and the other is wrong – they're just different (and arguably incompatible at this particular fault line in the system) (see Glasby, 2003; Heenan, 2023 for further discussion).

Box 3: Initiatives for improving delayed hospitals discharge: an international scoping review (Cadel et al., 2021)

This international scoping review argued that most of the current literature focuses on the risks of being delayed and the groups of people most likely to be delayed (i.e. some of the 'problems' to be solved) – not on practical solutions. In contrast, they reviewed initiatives that seek to tackle delays in order to identify best practice.

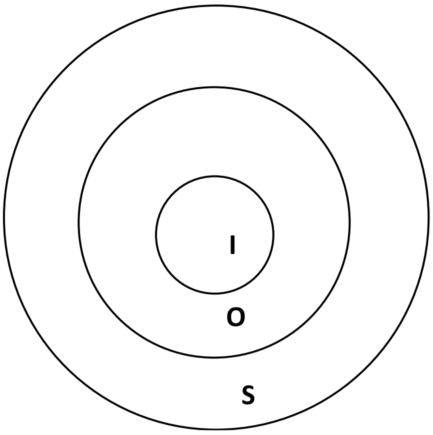
Their article is free to read (https://bmjopen.bmj.com/content/bmjopen/11/2/e044291.full.pdf), but summarises a number of practice changes, tools and guidelines, approaches to information sharing, and projects around infrastructure and finance that have been attempted in different parts of the world. A number (but not all) of these seemed to have some positive results – albeit the research to date tends to focus more on system outcomes than on the experiences of older people/families. There is also a lack of data over time (to see how sustainable any changes were) and a lack of information about the local context (making it difficult to share learning with others). It was also unclear whether some initiatives simply moved problems from one sector to another, rather than genuinely solving the problem. Overall, the review identified some potentially promising approaches, but also concluded that: *"This highlights the need to shift to a more patient-centred approach that focuses on improving outcomes and experiences, rather than system and hospital outcomes (i.e. length of stay and hospital occupancy) alone. Despite the number of unique initiatives aimed at addressing delayed discharges, current strategies may not be getting at the root of the problem… and there is a need for solutions to this problem that have a long-term and sustainable impact"* (p.26).

Even if we recognise that there are unlikely to be any ‘magic answers’, we might still be able to make progress by doing things such as:

- Focusing on the experiences of older people and on outcomes that matter to them. Although it is now very dated, there is a wonderful example of this in action from Age Concern Fife; another really good example comes from the work of SCIE (see Boxes 4 and 5). Neil Crowther (2023) from #SocialCareFuture has also written a beautiful blog about his Mother’s experience, what mattered to her, the support that helped and why this isn’t social care as we usually think about it.
- Focusing on doing what we can to go beyond the confines of our role/organisation/ profession in order to ensure that support is as joined up as possible. Rather than passing the buck off on others and getting frustrated with partner agencies, we need to acknowledge that this is often no one's fault - and spend more time looking for answers than blaming each other
- Local organisations establishing good relationships with each other and finding practical ways to smooth over some of the tensions and fault lines that get in the way of effective joint working. As but one example of the way in which partners can work together to better understand and respond to these issues, the report ‘Why not home? Why not today? sets out some practical suggestions and advice which may be of interest to local Networks (Better Care Fund/Newton, 2017).
- National policy makers trying to avoid the dangers of focusing solely on discharge at the expense of other issues and of viewing adult social care through an NHS lens. There may also be scope for more work nationally in order to remove some of the administrative, legal and financial barriers that get in the way of joint working, and better align different health and social care incentives so that joint working happens because of the system rather than in spite of it.

Interestingly, this suggests action at three different but inter-linked levels: individual, organisational and structural (the ‘IOS’ model - see Figure 1). Thus, the contribution of individual workers, although significant, takes place within an organisational context, which itself is influenced by structural barriers to improved joint working. Similarly, structural barriers derive at least in part from certain organisational features associated with particular types of health and social care agency and, ultimately, from the individual practitioners working within the organisations concerned. As a result, co-ordinated action might be needed at all three levels if we are to make significant progress.

Figure 1: The ‘IOS’ model of hospital discharge (Glasby, 2003)



I	**Individual level**
O	**Organisational level**
S	**Structural level**

Box 4- Focusing on things that matter to older people – insights from the Fife User Panels project

Although nearly 30 years old, an interesting example comes from work undertaken by the ‘Fife User Panels’ project. While there was a growing emphasis on involvement and engagement, many examples at the time focused on people of working age; it was much less common to seek to engage groups of frail older people in sharing experiences and exploring opportunities to improve care and support. Once they started meeting each other, the group quickly realised that they all had personal (and often negative) experience of hospital discharge. This included:

- “Being given no advance warning and being told during a relative’s visit that they could go home immediately
- Being packed and ready to go but having to wait hours until an ambulance service was available
- Returning to cold and empty houses with no services available until the following day” (Barnes and Cormie, 1995, pp. 30-31).

In response, they developed a practical guide to good hospital discharge – examples included:

- The heating should be turned on in the house from the morning of discharge. The bed should be made up and warm for the patient
- There should be fresh staple goods (such as milk, tea, eggs and butter) in the house
- One meal should be ready for the person coming home
- The home carer should be in the house awaiting the patient’s arrival if no friends or relatives are available or if requested by the patient

- Adequate notice of discharge should be given to family members (remembering that this person in turn will have to make their own domestic arrangements)
- Discharge times should be given within reasonable parameters (for example, whether discharge will take place in the morning, afternoon or early evening). People should not be kept waiting for hours
- At least 24 to 48 hours' notice of discharge should be given
- Services should be in place on the day of discharge, not the day after
- Services following discharge should be available 7 days per week, including public holidays.

This advice has since been built into senior NHS leadership development programmes in England, as part of an exercise to think about the insights provided by different types of evidence. In addition to a systematic review, a randomised controlled trial, professional guidelines and a national survey of carers, participants were given this good practice guide and asked which of the sources was the most valid/reliable, and which was the most helpful in terms of helping to tackle the issues at stake. Participants always felt that this material was really powerful (because it drew on lived experience) and very hard to argue with – we may or may not have a research study that 'proves' if it matters if someone's heating is on in advance, but not many people would disagree that an older person coming out of hospital in the middle of winter and late at night should come back to a warm house. Ironically, the advice given by the Panel is also fully consistent with all the research published on this topic over the last few decades (Glasby, 2003).

Box 5: Focusing on things that matter to older people – insights from SCIE's systematic review

In 2006, the Social Care Institute for Excellence (SCIE) sought to develop approaches to reviewing evidence that were rigorous and transparent, but which could include people's lived experience in a way that was less common in more medically-orientated research (which often focused on quantitative research about effectiveness) (Fisher *et al*., 2006). They chose to focus on hospital discharge - a topic which they felt had recently been subject to "a conventional, high-quality systematic review, but which lacks attention to the views of older people about what they value in terms of both process and outcomes."

By asking a different kind of question – focusing on older people's experiences, rather than on issues of effectiveness – they were able to prove that such approaches to reviewing evidence could be feasible and productive, producing different answers to reviews that adopted more traditional methods. In particular, they found that professionals often see discharge as a discrete event and focus on risk, safety and functional independence. In contrast, older people saw their hospital stay and discharge as part of a broader process of coming to terms with the impact of illness on their lives and future plans, and were often anxious about the implications for their self-sufficiency and the control they had over their own lives. They therefore really valued things such as education, training and continuity of staff to help them regain control and reduce uncertainty and anxiety.

Overall (p.48):

> *"The synthesis shows that, while health staff may know more about the physical effects of illness and its likely impact on daily life, they know much less about what this means for older people and their life plans. Older people know their own life plan, and what they fear might be the impact of the illness, but need carefully delivered information, and carefully constructed opportunities, to review their life plan in the light of their illness and to make their own plans accordingly. They also need the recognition that discharge might involve far more important issues (to them) than safety per se, and far more than being expected to accept passively any limitations consequent on illness. The synthesis shows that, in older people's eyes, coming to terms was not a passive process of acceptance but an active process of working out how to manage, and how to preserve control over the most important things while accepting what must be given up.*
>
> *Thus the value of this qualitative synthesis for the topic of older people and hospital discharge is that it reveals some of the mechanisms underpinning successful interventions to support older people after discharge, and that it points to a lifeplanning framework for understanding the impact of illness, admission and discharge. This life-planning framework is completely missing from the original review, and yet it has the capacity to change profoundly the construction of interventions to support older people through their experience of illness and hospital."*

Thus, the review produced practical learning for health and social services – but did so in a way which valued and built on people's lived experience.

Having read this discussion material:

1. Are there things in the document that remind you of your experience of hospital discharge?
2. What do you think can help or hinder older people from having a positive experience of discharge from hospital?
3. What do you think can support the experience of professionals involved in hospital discharge?
4. From your experience, is there any good practice which could help to address potential issues around premature/poorly coordinated discharge?
5. Reflecting on the list of advice from the 'Fife User Panels' project in Box 4, do you think these are in place in your local area?

References

- Age UK (2016) Age UK briefing – discharging older people from hospitals (www.ageuk.org.uk/globalassets/age-uk/documents/reports-and-publications/reports-and-briefings/care--support/age_uk_discharge_from_hospital_briefing_june_2016.pdf)
- Barnes, M. and Cormie, J. (1995) On the panel, Health Services Journal, 2 March, 30-31

- Better Care Fund/Newton (2017) Why not home? Why not today? (https://www.local.gov.uk/sites/default/files/documents/NEW0164_DTOC_Brochure_Online_Spreads_1.0.pdf)
- Cadel, L. et al (2021) Initiatives for improving delayed discharge from a hospital setting: a scoping review, British Medical Journal Open, 11:e044291. doi:10.1136/bmjopen-2020-044291 (https://bmjopen.bmj.com/content/bmjopen/11/2/e044291.full.pdf)
- Cavallaro, F. et al (2023) Why are delayed discharges from hospital increasing? Seeing the bigger picture. London, Health Foundation (https://www.health.org.uk/publications/long-reads/why-are-delayed-discahrges-from-hospital-increasing-seeing-the-bigger)
- Crowther, N. (2023) It's good to be on the road back home again. Online blog (https://makingrightsmakesense.wordpress.com/2023/06/13/its-good-to-be-on-the-road-back-home-again/)
- Fisher, M. et al (2006) Using qualitative research in systematic reviews: older people's views of hospital discharge. London, SCIE (https://www.scie.org.uk/publications/reports/report09.pdf)
- Glasby, J. (2003) Hospital discharge: integrating health and social care. Abingdon, Radcliffe Medical Press
- Glasby, J. and Lester, H. (2004) Delayed hospital discharges and mental health: the policy implications of recent research, Social Policy and Administration, 38(7), 744-757
- Glasby, J., Littlechild, R. and Pryce, K. (2004a) Show me the way to go home: delayed hospital discharges and older people. Birmingham, Health Services Management Centre/Institute of Applied Social Studies (on behalf of the Department of Health Policy Research Programme)
- Glasby, J., Littlechild, R. and Pryce, K. (2004b) Show me the way to go home: a narrative review of the literature on delayed hospital discharges and older people - research note, British Journal of Social Work, 34, 1189-1197
- Glasby, J., Littlechild, R. and Pryce, K. (2006) All dressed up but nowhere to go? Delayed hospital discharges and older people, Journal of Health Services Research and Policy, 11(1), 52-8
- Glasby, J. et al (2016) Who knows best? Older people's contribution to understanding and preventing avoidable hospital admissions. Birmingham, School of Social Policy/NIHR Research for Patient Benefit programme (https://www.birmingham.ac.uk/documents/college-social-sciences/social-policy/hsmc/publications/2016/who-knows-best.pdf)
- 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
- Holzhausen, E. (2001) "You can take him home now." Carers' experiences of hospital discharge. London, Carers National Association (now Carers UK)

- Ince, R. et al (2022) ‘Why are we stuck in hospital?’ Understanding delayed hospital discharges for people with learning disabilities and/or autistic people in long-stay hospitals in the UK, Health and Social Care in the Community, https://doi.org/10.1111/hsc.13964
- Poole, R., Pearsall, A. and Ryan, T. (2014) Delayed discharges in an urban in-patient mental health service in England, Psychiatric Bulletin, 38(2), 66-70

Cover image – Wilson Ren: https://www.pexels.com/photo/lit-up-exit-sign-in-a-hallway-5036652/

Website: **impact.bham.ac.uk**
X: **@ImpAdultCare**
LinkedIn: **impadultcare**

Hospital discharge is a really difficult area of policy and practice for a range of reasons – but it tends to hit the headlines because of the impact it has on the health service, rather than the impact it has on older people and families.

In practice, both are important – but we need to make sure that we're focusing on outcomes that matter to people and that we don't only see adult social care through the lens of the NHS.

What matters to older people and families?

An Ask IMPACT guide

Putting hospital discharge in context

In 2023-24, IMPACT has been running one of its national Networks on hospital discharge for older people, with groups all over the UK working on practical, evidence-informed changes in their local area and sharing learning about what makes a difference. This has revealed some helpful context to help introduce this guide.

Coming out of hospital has been a really difficult area of policy and practice throughout the history of the NHS and social care. It is also really difficult in lots of other countries around the world.

This might suggest that we struggle with it, not because we are not trying hard enough, but because it is really difficult (and built into how our services are designed). If it was easy, we would probably have solved it by now.

When health services in particular are under lots of pressure, the focus is often on tackling delays in leaving hospital, thereby freeing up hospital beds for new people to be treated. While this is really important for all of us, we also need to think about the impact that coming out of hospital has on older people and families, not just on the ‘service issues’ involved.

The dangers of getting it wrong

All the evidence suggests that coming out of hospital either before you feel ready, or without the right planning and support in place, can be really distressing and have really serious consequences. Sometimes we miss these because they often happen in private, behind closed doors – and we are busy trying to support the next person who is ready to leave hospital. There’s a also a risk that we can be so focused on getting people out of hospital, that we don’t do enough to keep people healthy and well at home (i.e. stopping people having to go to hospital in the first place).

More generally, these are such key issues that it can sometimes feel as if hospital discharge is dominating social care (particularly in some media accounts). Although helping people come out of hospital quickly and well is really important, social care is about much more than this – and attempts to improve discharge shouldn’t encourage us to do anything that makes it harder for people to lead ordinary lives in a place they call home. When there are lots of pressures on hospital services and lots of national scrutiny, it can sometimes lead to calls for short-term, single agency or knee-jerk responses. In our experience, this rarely solves the underlying issues, and could make things worse.

This guide

Instead of focusing on 'freeing up hospital beds' - important though this is - this guide looks at things that the evidence suggests matter to older people and families – some of which might not always be things that services think about as much as they perhaps could.

This should not get in the way of official policy and practice guidance already in place in different parts of the UK or the different initiatives and good practice examples that exist in different nations. However, this guide sets out some things that we could easily miss if we were not really focused on the needs of individual people.

Having reviewed the evidence, this guide focuses on six key issues:

- Feeling 'forced out' too soon
- Feeling confident that the practicalities are in place
- Feeling a 'burden'
- Paying attention to emotional and social issues
- Good communication
- Feeling 'done unto'

> **"Delayed hospital discharge experienced by people who can't return home for lack of social care support is a *symptom* of the multiple faultiness in adult social care, it is not *the problem to be fixed.*"**
>
> **Neil Crowther, #SocialCareFuture**

[A note on terminology – when we talk about 'going home', we mean returning to the place that the person calls home, whatever type of housing this is and irrespective of whether it's someone's own home, living with family or living in some sort of group setting. The key thing is that it's home from the point of view of the person].

Feeling ‘forced out’ too soon

Although lots of policy focuses on tackling delays in being able to leave hospital, there is also a risk that some people feel ‘forced out’ before they’re actually ready (premature rather than delayed discharge).

Most people want their stay in hospital to be as short as possible, really appreciate the support they receive from different hospital staff and do all they can to be able to go back home as soon as they can.

However, people also have a clear sense that “sometimes you need to be in hospital” [Fowler Davies, S. et al (2019) Hearing the voices of older adult patients: Processes and findings to inform health services research, p. 4] and can feel “‘ejected’ from hospital – relieved, but also anxious about leaving the acute care environment” [O'Hara, JK et al (2020) 'Handing over to the patient': A FRAM analysis of transitional care combining multiple stakeholder perspectives, p. 9].

This could be because they still feel unwell, because there have been complications in their care and/or because they feel anxious about what might happen next and need further support and reassurance. It can also link to the sense of ‘feeling a burden’ discussed below.

This means that everyone involved in the discharge process needs to be focused on helping people get home as soon as possible, but has to work at the pace of the individual older person. This sounds basic, but is really important – and also very difficult to do in such busy and pressured environments.

Feeling confident that the practicalities are in place

The transition from hospital to home can feel daunting, leaving some people “feeling overwhelmed… by unforeseen difficulties” [British Red Cross (2018) Home into the unknown: Getting hospital discharge right, p. 12].

As part of this, there can be lots of practical matters to think about – often at a time when people are coming to terms with what’s happened to them and might feel least able to cope with some of the issues. This can include:

- Getting home from hospital in the first place (e.g. practical transport issues)
- Making sure the heating is on, things are clean, the bed’s been changed and there’s food in in a home that might have stood empty for some time
- Having the lights on so that someone isn’t coming into a dark house if it’s late night
- Starting up previous care and support arrangements – this can sometimes be really difficult, especially if it’s at short notice or at night/over the weekend
- Feeling able to manage your own home and daily routine if you’re still recovering from ill health or if your mobility is temporarily reduced
- Taking any new medication and using any new equipment that might have been provided
- Attending any subsequent appointments and making sure that anyone who is meant to be following you up in the community does so in a timely manner

When these practical arrangements fall down, it usually falls to the person and their family (if they have a family nearby) to manage these themselves. Many people say they feel overwhelmed, and some families say they feel that the system gives them no choice – they’re expected to step in, often without really being asked, sometimes irrespective of where they live, what’s going on in their own lives or what kind of relationship the family has.

Above all, getting the practical help you need can be utterly baffling and incredibly stressful to anyone who doesn’t already understand how the health and social care system works (which is most of us).

Feeling a 'burden'

We may be trying our best to juggle multiple competing demands in our work, and to be supporting individuals as best we can – but older people in hospital are often aware of the general pressures surrounding them on the wards.

These pressures can shape how staff and patients interact, and people can feel excluded from the care process if staff appear unapproachable and seem too busy to really listen. Several accounts describe how some older people may "do as they are told" for fear of being seen as "a nuisance" (Hardicre, N. et al (2021) Doing involvement: A qualitative study exploring the 'work' of involvement enacted by older people and their carers during transition from hospital to home, p. 1941) – or may not ask for help or feel comfortable being open with health professionals.

In an ageist society, this can make people feel as if they're 'a burden' and not deserving of support. This is particularly an issue when there are media accounts of 'bed blocking' – as if the person is somehow deliberately occupying a bed that someone else needs (when in reality they're probably desperate to get home). In our view, this just blames the victim – people are sometimes stuck in hospital beds because we can't find a good way to support them at home.

The consequences of all this – for people's confidence and well-being, and in terms of people feeling comfortable seeking help, raising concerns and accessing services that should be available for everyone – can be really harmful.

Even if we can't find a way to improve some people's discharge from hospital, the least we can do is make sure we don't make older people feel guilty or worse about themselves.

Paying attention to emotional and social issues

"When you come out of hospital, you get back to your flat and you're different. Mentally you're different because your life has changed, so you've got to do things in a different way." [British Red Cross (2018) Home into the unknown: Getting hospital discharge right, p. 7].

While services are often focused on discharge as a physical transition between different settings and locations, it is also an emotional and social experience for older people and families.

For some people, being in hospital is "often defined by trauma and uncertainty and characterised by a loss of control and heavy reliance on others" [British Red Cross (2018) Home into the unknown: Getting hospital discharge right, p. 33] – and people consider recovery and discharge less in terms of their medical condition and more in terms of a return to normality and a greater sense of control at home.

There can also be broader issues – such as getting used to receiving care and support potentially for the first time, feeling comfortable with new equipment, coming to terms with longer-term changes that might be taking place in your life, and feeling worried for the future.

We might be desperate to leave hospital and get home – but it can also be a time of significant anxiety, fear and distress.This can be really difficult for the professionals involved, who are often under significant pressure to act quickly (knowing that rapid, quick-fire actions can sometimes be counter-productive).

Good communication

"Three weeks after her stay, Angela still wasn't sure why she was admitted to hospital, nor who was responsible for her care once she was discharged. She was unsure about what the next steps for her recovery were, particularly after receiving a letter from the hospital which she found very difficult to understand. She didn't know who to contact when she got home." [British Red Cross (2018) Home into the unknown: Getting hospital discharge right, p. 36].

Lots of people feel that they don't get meaningful, accessible information when they're leaving hospital – about what's happening in the short-term, about longer-term options, and about specific issues such as medication, how to contact key people and who is responsible for what.

All the evidence suggests that people and families value good communication, and see it as key to helping them understand what's happened to them, what will happen next and what might happen in the long-term:

"I wouldn't say there was any real plan at all […] – you're just kind of dumped in it." [British Red Cross (2018) Home into the unknown: Getting hospital discharge right, p. 37].

Longstanding and common issues include:

- Difficulties experienced by families contacting the relevant hospital staff during the person's hospital stay
- Not knowing who is taking the lead in organising and co-ordinating the discharge
- Hospital staff talking to the older person when it's convenient for the hospital, rather than when it's the best time for the person – and not always communicating fully with families
- People feeling that information is sometimes delivered as a 'monologue' with little opportunity to seek clarification or ask questions
- Too much professional and technical jargon
- Professionals not fully appreciating the emotional impact of being in hospital, and so mis-judging the person's state of mind or readiness to receive the information in question
- Different professionals prioritising different things, so that everything feels confusing and not joined up
- No one really talking to the person about what they want and how they best get back to a sense of normality after hospital

Feeling ‘done unto’

We all want to be involved in decisions about our own care – and we usually get better outcomes when the relationship between care professionals and the person is based on a partnership.

This can be difficult in some hospital environments, where things might be very pressured and busy, where there may be little space for private conversations and where it can be difficult to have the time to make potentially long-term decisions. People are often feeling really scared and ill, so might need support to feel comfortable speaking up, sharing what they’re really feeling and possibly even taking a different view to the health professionals around them. Some cultures have historically been quite hierarchical – and some older people might be used to the traditional view that ‘doctor knows best’ (even if this isn’t what the doctor thinks at all).

All this means that it can be easy for people to feel excluded from decisions about their own care and helpless about what happens to them next.

All this is really problematic, because we know that:

- People and families are experts in their own situation, their aspirations and what would work for them – overlooking this is to neglect a vital source of expertise that could lead to much better outcomes
- Families in particular can feel excluded and taken for granted by some health and care professionals
- If you feel ‘done unto’, it can really damage your confidence and self-esteem – and also make it difficult for people to feel comfortable regaining greater control over their lives and support when they get home

Summary

Hospital discharge is a key ‘fault line’ in our services – between being ‘unwell’ and ‘well’, between hospital and community, between health and social care, and between people from different professional backgrounds.

It’s always been difficult to get this right – especially when services are under significant pressure - and most countries struggle with it.

All this means that it’s easy for older people and their families to feel lost, overlooked, ‘done unto’ and sometimes even ‘forced out’ too soon.

While it’s important that everyone is focusing on supporting people to leave hospital and return back to wherever home is for them, some of the things that really matter to people include:

- Feeling in control of what’s happening to you, in the place that you call home
- Working at the pace of the individual
- Paying really detailed attention to getting the practicalities right
- Making sure that we don’t fall into the trap of making older people feel like a ‘burden’
- Recognising that being in and leaving hospital is an emotional and social issue, as well as a physical transition between different settings
- Meaningful, two-way communication and relationships, with a partnership of equals

Despite all this, leaving hospital is also a chance for health and care professionals to make a real difference to people and their families, at a time when many of us feel at our most vulnerable. Getting it right for people and families, and seeing it through their eyes, is crucial.

About this guide

Ask IMPACT materials are designed to be trusted, accessible and practical. They are based on reviewing evidence – including research, lived experience and practice knowledge – that is captured on academic databases and on the websites of adult social care policy and practice organisations. The HSMC Knowledge & Evidence Service (KES) is a specialist information service providing a range of research, communications and information literacy skills services to the health and social care community. The evidence search conducted covered material published between January 2017 and January 2023. To find out more about KES, or about the searches behind this guide, you can contact them at: hsmc-kes@contacts.bham.ac.uk

IMPACT
Improving Adult Care Together
UKRI
Economic and Social Research Council
The Health Foundation

John Bolton OBE

Former Visiting Professor Oxford Brookes University – Institute of Public Care (IPC)

Independent Consultant in Health and Social Care

Senior Adviser – Newton

Published Work in Wales

- Right Sizing Community Services for Older People in Wales
- Joint programme with NHS Delivery Unit (Wales) and Welsh Government
- Report Published in 2020

- Better Support at Lower Cost –SSIA Efficiency Programme 2011

- Reducing delays in Hospital Transfers of care for older people
- https://ipc.brookes.ac.uk/publications/pdf/Some_key_messages_around_hospital_transfers_of_care.pdf
- Commissioning out of hospital care services to reduce delays
- https://ipc.brookes.ac.uk/publications/commissioning-out-of-hospital-care-services-to-reduce-delays/

My work findings

- Most people leaving hospital (including older people) need time to recover before an assessment is made for their longer-term care – Discharge to recover then assess
- All recovery should either be therapy led, or nursing led (not care led)
- Health run “urgent response services” (nursing) in the community are equally valuable to Local Authority commissioned domiciliary care reablement based services – there are a shortage of both these services in parts of Wales
- About one third of admissions direct to permanent residential care from hospital are avoidable or premature. Older people who are considered that they may be needing permanent residential care should first use a bedded intermediate care setting service to support their recovery.
- Demand is in part a construct of how a local system is set up from the acute hospital to the post hospital care on offer
- In most systems it is a lack of the right capacity that drives demand into the wrong services – need to understand how the local capacity works (supply) and how that impacts on demand

Emerging issues

The patient experience in hospital contributes towards their needs at discharge

Frailty can be reduced if appropriate help offered – hence reducing care needs

The wrong supply - doing harm?

- Spot-Purchased Residential Care where there is a lack of therapy in-put to focus in helping people get back home (less than 20% return home) – Discharge to Dump – 66% home with right service
- Domiciliary Care where there is no therapy input to focus on helping people make a good recovery (Less than 40% make any recovery) – 66% recover with right service
- Where older people with dementias are placed in mainstream services that are not established for that purpose – high risk of breakdown. Where there are no community IC services for people with dementias to return home (high use of residential care).
- These services are all used at the point of discharge to fill the gap between demand and capacity!

Conclusion

- Not sufficient of the right type of Intermediate Care to meet health and care needs of older people leaving hospital
- Problem is not for social care or for NHS but how both work in partnership

Right Sizing Community Services to Support Discharge from Hospital

May 2020

Executive Summary

When assessing the capacity required to support discharge and deliver Discharge to Recover then Assess (D2RA) pathways, Regional Partnership Boards (RPBs) need to ensure that; Primary / Community / Third Sector options are optimised. No-one is assessed for long term care (package or placement) in an acute hospital bed; and no-one waits longer than 48 hours, after their acute treatment is complete for their Discharge to Recover then Assess (D2RA) pathway to commence.

Too many people are still bypassing intermediate care. No patient should be assessed for long term care (packages or care home placement) in an acute hospital bed.

Discharge to Recover then Assess pathways should be in place in all RPB / HB areas to ensure 'effective assessment, at the right time, of the right type, and be outcome focussed' to maximise individual outcomes and system flow.

The proportion of people currently placed on D2RA pathway 3 (bedded intermediate care) is greater than good practice would suggest should be the case. Capacity must increase for all patients who would benefit from D2RA pathway 2 (in their own home).

Health Boards should review the service model for Community Hospitals. Community Hospitals in Wales are frequently used as 'step down' facilities and can be the default pathway for complex discharge. However, the environment and variation in therapy input means that the outcomes for individuals are variable.

Regional Partnership Boards should review their services for people with Dementia. People with Dementia can be excluded from current intermediate care service provision. There is early indication that access to specialist Dementia services developed in areas of Wales can produce good outcomes for this client group.

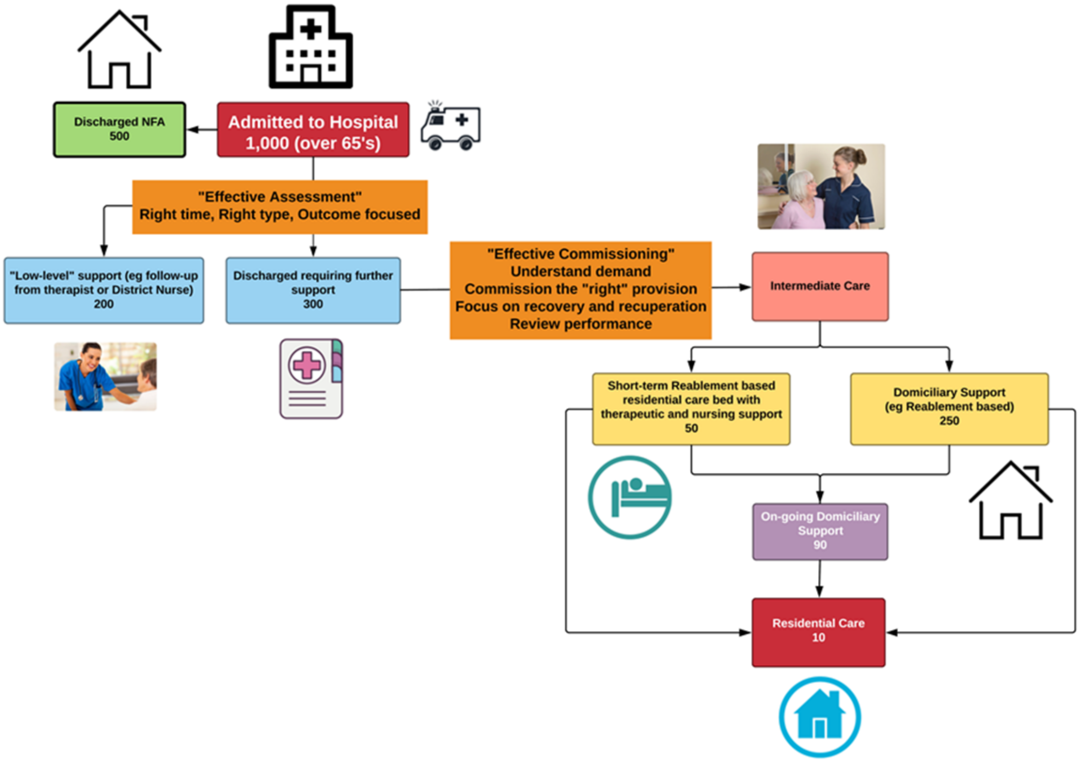
Background

In autumn 2018, the NHS Wales Delivery Unit (DU) published the report of its national review of complex discharge practice in Wales. It identified significant opportunities to improve the experience of the people we serve by reducing harm and improving patient flow.

One of the key themes identified as benefitting from a national approach was right-sizing community services to facilitate timely discharge (including the four 'Discharge to Recover then Assess' pathways – see **Appendix 1**).

This project has been developed to respond, in a systematic way, to that request using the model[1] developed by Professor John Bolton set out below:

Diagram 1: The model



---

[1] Professor John Bolton, Reducing delays in hospital transfers of care for older people Key messages in planning and commissioning (Institute of Public Care, Oxford Brookes University).

The model had been presented at a number of national events over the previous two years and the feedback suggested that it had resonance amongst those who attended.

In the paper in which this model appears, Prof Bolton explains that it:

"……is designed to describe the system (he) feels should be developed to assist in managing post hospital care. The numbers in the diagram indicate what good practice might look like.

The diagram suggests that about a third of people leaving hospital should need some care and support, and most of those (around 85%) can be helped at home. The numbers ending up in residential or nursing care as a new admission on a permanent basis following a hospital episode should be very low (less than 4%).

The key message conveyed by the illustration, is that ***each component of the model needs to understand the flow of patients, the outcomes achieved and the overall performance of the health and social care system."***

Note: this Project focused on right-sizing community services for discharge. Further work is required to also understand the resourcing required to right-size community services to more effectively manage care closer to home in the first place. This will form part of the NHS Wales Delivery Unit's 2020/21 work programme.

Purpose

The purpose of this national project was to support Regional Partnership Boards (RPBs) to assess:

- How the patient numbers in their region compare against the model;
- The potential variance between current commissioning arrangements and current/future demand if the principles of the model are implemented via the Welsh Discharge to Recover then Assess Pathways 2, 3 & 4. (**Appendix 1**)**;** and
- Whether the services they currently have in place support these patients/customers and deliver good outcomes.

Project methodology

Details of the Project Team, National Advisory Group, definitions and methodology used are attached as **Appendix 2.**

What did the data tell us? (Quantitative Analysis)

It quickly became apparent that our health and social care systems in Wales are not currently set up to systematically collect the data required to inform the integrated commissioning of community services.

There was an initial assumption that the Welsh Community Care Information System (WCCIS) would provide this function, but this is not the case at present. As a consequence, the data collection exercise has been challenging for all areas and continues to be an iterative process.

All of the RPBs have gone on to review and refine their data in order to provide more confidence in their local information and, in response to the project timescales, are currently at different stages in that iterative process.

In the course of the Project, the template and definitions for data collection have also been refined in order to provide greater clarity and to facilitate regular update and review, as part of the RPB integrated commissioning process.

<u>‘Support in the Community’</u>

In the original model, this was described as ‘Low Level Support’. The terminology has been changed to reflect the feedback that ‘low level’ could be misinterpreted. The type of service that the newly phrased ‘Support in the Community’ refers to includes:

- Short-term (usually third sector) services developed specifically for discharge. Tasks undertaken commonly include making sure heating is on, escorted transport home, shopping, meal prep, support to go out, and making community connections. Where personal care is provided, the service would be captured under one of the yellow ‘non-bedded intermediate care’ boxes;

- Single (usually NHS) profession follow-up post discharge e.g. district/community nurse for dressings, physiotherapy outpatient appointment etc.

<u>Non-bedded Intermediate Care</u>

In the original model this was called ‘Domiciliary Support ‘. This refers to recovery and assessment in an individual’s own home (D2RA Pathway 2) and commonly includes an element of domiciliary care reablement plus appropriate multidisciplinary team input as required.

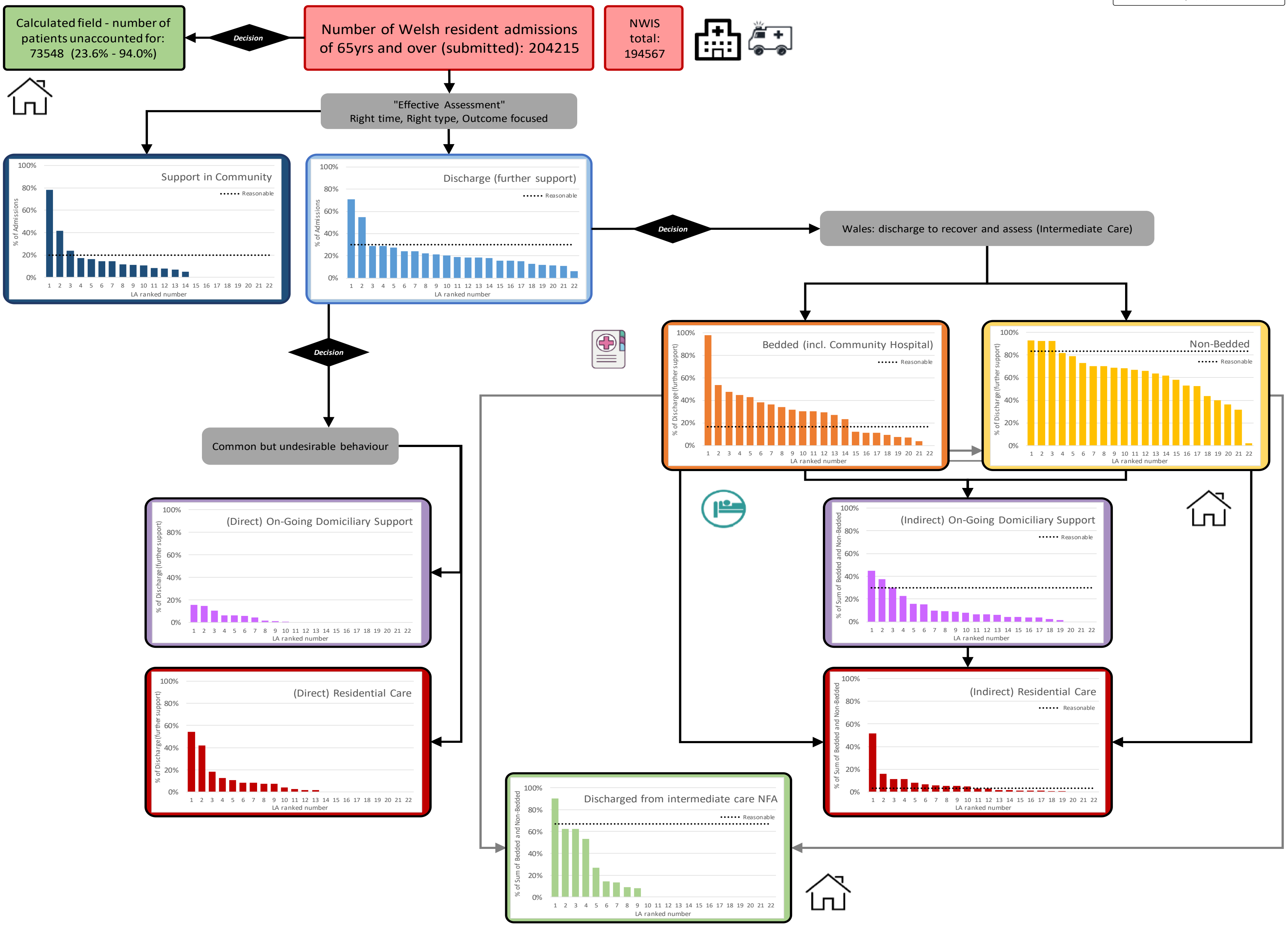
<u>Bedded Intermediate Care</u>

In the original model this was called ‘Short term reablement… bed’. This refers to recovery and assess in a bedded facility (D2RA Pathway 3). This can either be commissioned from the independent/third sector or, as is commonly the case in Wales, provided in a Community Hospital.

Diagram 3: Populated Template (showing range across Wales)

Managing the flow out of hospital: (Admissions 65yrs and Over - 2018/19)

Key: Dotted line on graphs is used to depict the reasonable activity level, based on JB model.



Calculated field - number of patients unaccounted for: 73548 (23.6% - 94.0%)

Number of Welsh resident admissions of 65yrs and over (submitted): 204215

NWIS total: 194567

"Effective Assessment"
Right time, Right type, Outcome focused

Wales: discharge to recover and assess (Intermediate Care)

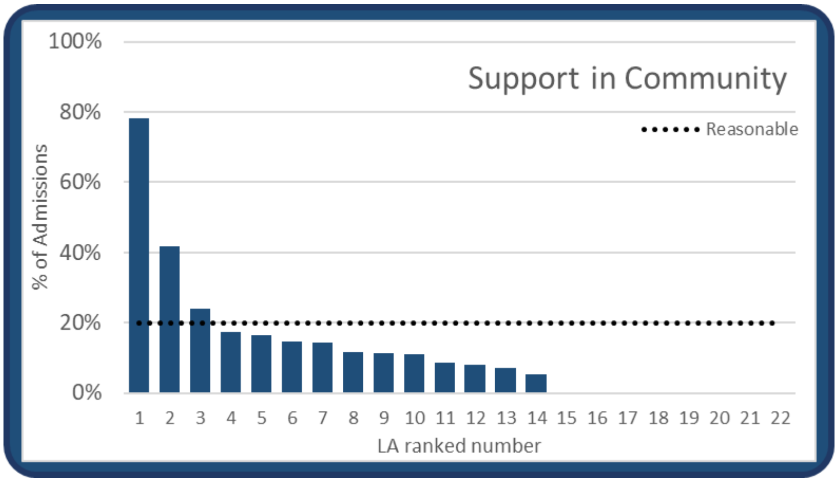
Common but undesirable behaviour

Diagram 3 above is an all Wales collation of 2018/19 data submitted by each of the health boards and the 22 local authorities relating back to the model in Diagram 1, but with On-Going Domiciliary Support and Residential Care split between Direct and Indirect placements where data allowed. The dotted horizontal line on each graph is the suggested level 'reasonable could look like' as detailed in Prof Bolton's paper.

The percentages illustrated in Diagram 3 are calculated using different denominators depending on the stage of the pathway – these are specified on each graph.

The data in each step of the model has been ordered in descending order based on the percentage of services. Due to the above ordering, a local authority may appear as bar 1 in one graph but bar 22 in another, hence the results are therefore pseudonomised.

Support in the Community

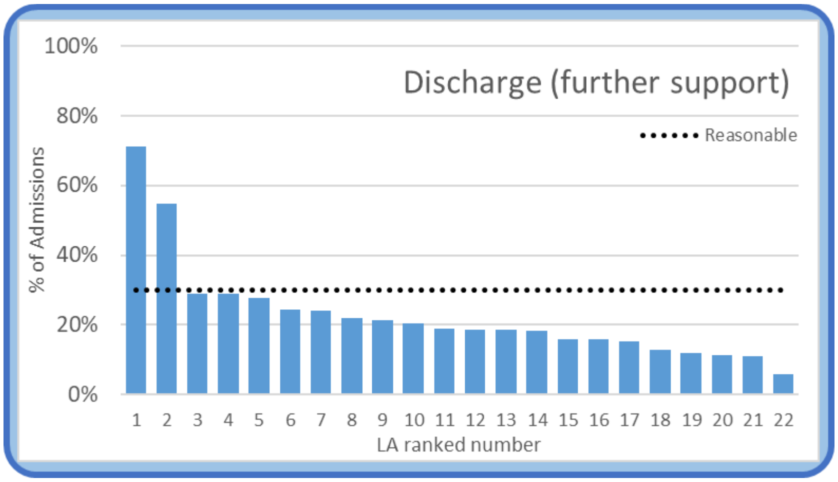


Whilst three local authority areas met or exceeded the reasonable proportion of patients discharged with this type of support (20% of admissions), the (caveated) data submitted indicates that there is significant opportunity to utilise this option more effectively, and to potentially avoid over-referral to intermediate care 'to be on the safe side'.

It is noted that not all areas submitted data for this type of support, and where they did it was not always complete i.e. contained one or two elements only.

Discharged Requiring Support

1. Access to Intermediate Care/Discharge to Recover then Assess Pathways 2 & 3:



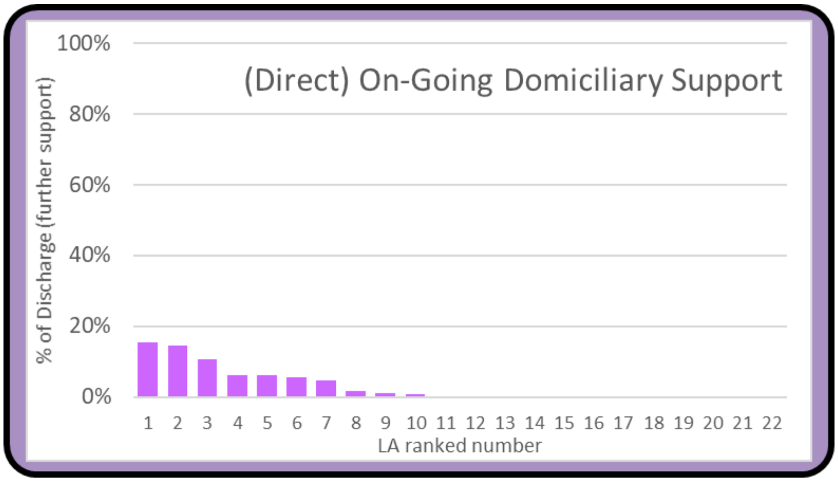
The proportion of older people leaving hospital who were assessed as needing care and support was variable.

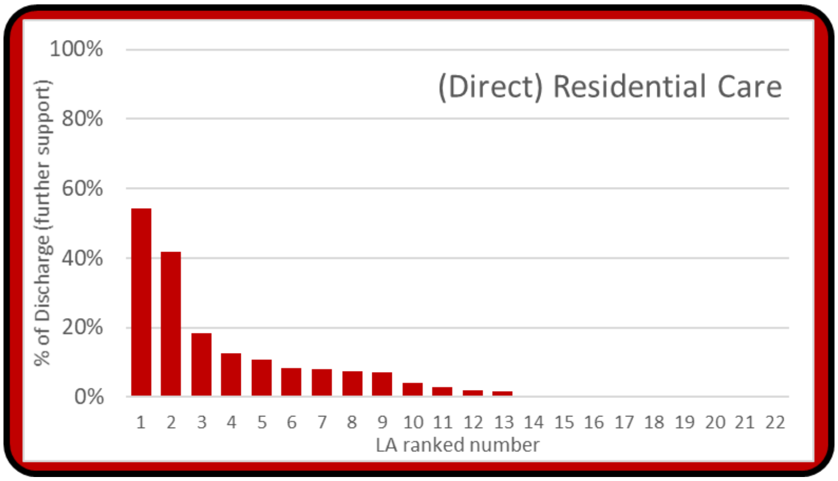
On average in Wales, 1 in 5 older people were assessed as requiring support on discharge from hospital, compared to the reasonable level of ‘about a third’ suggested in Prof Bolton’s paper and quoted on page 4 of this report.

However, caution is needed for this figure at this stage, as some areas were not confident in their submitted data and revised versions may impact on this finding.

What is clear is that the data, as currently presented, showed a very wide range from 6% to 71% of older people leaving hospital currently assessed as requiring intermediate care/Discharge to Recover then Assess Pathways.

The data illustrated below also indicated that too many older people were assessed in an acute hospital bed for longer term care packages or new care home placement. This data further supports previous DU findings in national discharge audits undertaken in 2016 -2018.

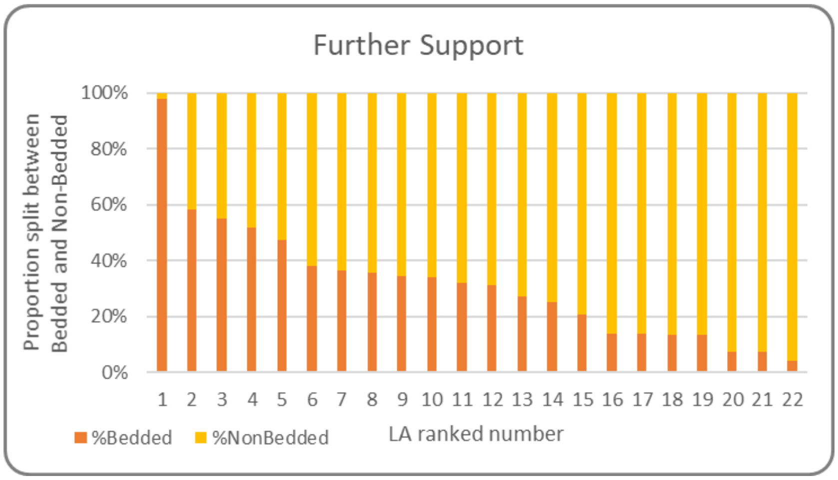




These two ‘direct to’ steps were added in at the template phase to disaggregate between those going through intermediate care and those not. Hence these do not have a suggested reasonable level – other than this direct route being undesirable, so the closer to 0% the better.

However, please note that some areas were unable to disaggregate new and existing care home placements from their current discharge information and so provided no data for this graph. Further work is required to gain a better picture of this behaviour and explore the true extent to which this occurs.

2. Home-based (D2RA Pathway 2) v Bed-based (D2RA Pathway 3) support



As stated previously, there is an expectation that around 85% of the older people needing support following discharge, should be managed at home (the ‘Home First’ philosophy).

However, in many places in Wales, more people assessed as requiring care and support were likely to be placed in a bedded facility than might be expected.

There was significant variation in what happens in different parts of the country with a range from 4% to 98% of people, on an intermediate care pathway, placed in a bedded facility.

The average is in the region of 30% which still appears high (compared with the model’s value of circa 15%).

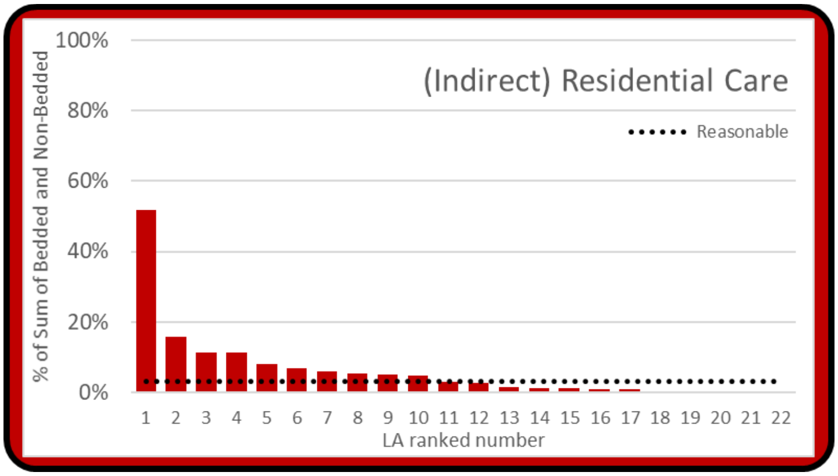
Outcomes from Intermediate Care Services

The paper describing this model highlights that circa 65% of older people receiving intermediate care in their own home should be expected to require no further ongoing care.

Over 70% of older people receiving intermediate care in a bedded facility should expect to return to their own home

Although many services did achieve the good practice standard, this was not universally the case. Potential reasons for this were discussed at the workshops and are reflected in the qualitative analysis section below.

The variation observed across Wales, particularly with regard to the percentage of people going on to care home placement, indicates that there is opportunity for improvement.



Those who received support in the community, including domiciliary care reablement, were more likely to experience a positive recovery. In other words, community/home-based intermediate care services in Wales appear to be generally effective, where people have prompt access to them.

The question is whether such services are available in sufficient capacity to support such recovery for everyone who could benefit from it, in a timely manner (i.e. within 48 hours)?

What did the ‘So what?’ workshop conversations tell us? (Qualitative Analysis)

The workshop discussions sought to understand the ‘story behind the numbers’. Common themes emerged, which generally reflected what the data appeared to indicate.

- There is still plenty of opportunity to maximise personal outcomes and system efficiency through getting the right people onto the right Discharge to Recover then Assess (D2RA) pathway. This will ensure that the support delivered is:
  - ✓ based on more accurate assessment in ‘the right place’;
  - ✓ co-produced and focussed on the outcomes that matter to the individual.

- In some/many areas however, acute hospital teams continue to over-refer to intermediate care or direct to long-term care pathways, when short-term, ‘low-level’ support could be a safe and sufficient option.

- In general, we do not (as yet) have the required capacity in the services designed to support people to be discharged to recover and be assessed in their own homes, in a timely manner i.e. within 48 hours of completion of acute hospital treatment. (D2RA Pathway 2.)

- There is of course the question of the over prescribing of care to which the evidence points[2]. Councils and Health providers need to be mindful of this so that episodes of care can be reduced or stopped as soon as it is appropriate. This will require review during the D2RA Pathway, e.g. after 2 weeks, rather than at the end or a pre-prescribed period of intermediate care (commonly circa 6 weeks).

- Where these services are in place in Wales, they are (on the whole) effective and achieve good outcomes for people. Rather than creating new initiatives, there is evidence to support up-scaling what works.

- As a result of lack of capacity for D2RA Pathway 2 (and possibly traditional bed management practices) too many people requiring ongoing support following admission to our acute hospitals are defaulting to <u>bedded</u> intermediate care facilities (D2RA Pathway 3).

- Many areas use community hospitals for this purpose, with smaller numbers commissioned from care homes. There is variation in the reablement approach in both environments, and consequently there is variation in the outcomes for

---

[2] Why not home? Why not today – Better Care Support Programme (England) 2017.

people on this pathway. There is opportunity, and enthusiasm, for further national work to maximise the effective use of community hospitals in Wales.

- There is evidence to suggest that individuals can be admitted to prematurely to care home placement or require large long-term care packages. In other words, we are creating additional ‘failure demand’ in an already stretched system.

- People with mental health co-morbidities, NB dementia, are often excluded from intermediate care services and D2RA pathways. Some areas have developed specialist services to support this client group and appear to be achieving good outcomes. All of the partnerships we worked with recognise that this an area that requires further attention.

- A number of people have their pre-admission domiciliary care service reinstated within a set timeframe, e.g. using trusted assessor models. For some this is very important, but for others, they might benefit from a period of reablement to assist in reviewing their life style (to see if some changes may be advised in order to reduce the risk of a further episode of acute care).

- We need national outcome measures to monitor and review the performance of services delivering Discharge to Recover then Assess across Wales. The measures included in the paper cited throughout this report were considered to be reasonable by RPB workshop participants, and are attached as **Appendix 5**.

- There was a repeated perception that sustainable development of, and recruitment into, intermediate care services is challenged by short-term funding mechanisms in Wales.

  There are positive initiatives funded by the Integrated Care Fund and Transformation Fund. However, where proved to be effective, these need to be ‘mainstreamed’ into core provision if they are to be sustained.

Conclusions

All the Regional Partnership Boards (RPBs) felt that the Prof Bolton model (**Diagram 1**) is a useful guide for integrated commissioning of services to support discharge from hospital.

The data collection and review needed to inform that commissioning will be an iterative process. Further work is required in many areas to get to the point where there is collective confidence in the joint information. The RPBs are, at time of reporting (February 2020), at varying stages in this process.

The learning from the pan-Wales exercise has built on the model and provided further information to inform the evidence-base.

It is clear that balance is required to ensure that the right people are placed on the pathway, so that such services are not over-prescribed where other support in the community (such as third sector) would be as effective for the individual.

Factors that will come in to play when achieving that balance include:

- Risks of deconditioning in the hospital environment;
- The risk averse nature of some assessments (influenced by timing, place and focus);
- ‘Low level’ service availability;
- Demography and community resilience (NB in rural areas).

The proportion of older people requiring intermediate care support in Wales, via the Discharge to Recover then Assess Pathways 2 & 3, may therefore be considered as being within a range of between 20% and 30%.

When calculating the capacity required in their community teams to deliver D2RA, the RPBs need to ensure that:

- Community/third sector options are optimised;
- No-one is assessed for long-term care (packages or placement) in an acute hospital bed; and

- No-one waits longer than 48 hours, after their acute treatment is completed, for commencement of their D2RA pathway.

This project has highlighted that too many people are still currently bypassing intermediate care and are being assessed for long-term care (packages or care home placement) in an acute hospital bed.

The outcomes for people who are able to access intermediate care/D2RA Pathways in Wales are generally good, though there is variation and therefore opportunity for continued improvement.

For various reasons, the proportion of people currently placed on D2RA Pathway 3 (bedded intermediate care) is greater than good practice would suggest should be the case, and there is currently insufficient capacity for all patients who would benefit from D2RA Pathway 2 (in their own home) to access those services in a timely manner.

Community Hospitals in Wales are frequently used as ‘step-down’ facilities and can be the default pathway for complex discharge. However, the environment and variation in therapy input means that the outcomes for individuals are also variable.

People with dementia are too often excluded from current intermediate care service provision. There is early indication that specialist services developed in Wales can produce good outcomes for this client group.

Recommendations and Next Steps

This is the start of a process.

To deliver for the people of Wales, the following actions will need to be implemented and further NHS Wales Delivery Unit support has been offered to the Regional Partnership Boards (RPBs) to continue this work:

a) RPBs should continue to refine and regularly review the data collected, using the updated template.

b) There is an expectation that this information will be used:
   - Prospectively for integrated commissioning of the intermediate care services required to deliver Discharge to Recover then Assess (D2RA) Pathways 2 & 3 their area; and
   - Retrospectively to monitor performance and outcomes for people using those services.

c) Services to support recovery and discharge, which have been tested and proven successful using short-term funding (including the Integrated Care Fund and Transformation Fund), need to be fully embedded into core service provision.

d) RPBs need to assure themselves that they are maximising the potential of third sector ‘Support in the Community’.

e) RPBs need to achieve the recommended balance of community/home-based v bedded intermediate care in their area, including the recruitment and retention of the appropriate workforce.

f) The role and function of community hospitals needs to be considered, potentially on a national basis.

g) RPBs should consider how people with dementia can be offered equitable opportunity for Discharge to Recover then Assess, including the provision of specialist services.

h) RPBs (and potentially Welsh Government) should consider using the measures listed in **Appendix 5**, to monitor and review the effectiveness of services delivering Discharge to Recover then Assess Pathways.

This Project focused on right-sizing community services for discharge. Work is also required to understand the resource/capacity required to right-size community services to more effectively manage care closer to home to avoid unnecessary hospital admission. The Delivery Unit has already commenced scoping this with partners.

It is a vital element of the whole system approach and cultural shift required to deliver care closer to home and achieve the best outcomes for the people we serve. This and other enabling pieces of work will be supported by the Delivery Unit, in collaboration with other national programmes and agencies in 2020/21. For further information or queries in relation to this report, please contact deliveryunit@wales.nhs.uk

APPENDIX 1

‘What Matters to me?’ is established with individual to identify the most appropriate Discharge to Recover then Assess Pathway for them

D2RA Pathway 1: Front Door Turnaround

Is this person fit to admit?

Comprehensive assessment at the hospital front door

Assess, treat and support at home

D2RA Pathway 2: Home First!

Why not home? Why not today?

In-patient treatment is complete

Default pathway for anyone who may need new or increased support at home, or a care home placement

D2RA Pathway 3: IC bed

Are we providing the right conditions to maximise recovery & independence

Should only be considered if Pathways 1 & 2 are not appropriate for this individual i.e. they have high dependency and overnight needs that can't be met with short-term night sitting.

D2RA Pathway 4: Existing Care Home

Providing the least disruptive path & maximising recovery

Same as Pathway 2 , with special considerations for delivering support within an individual's **existing** care home placement

Assessment for **new** placement must follow Pathway 2 or 3

APPENDIX 2

Project methodology

The Project Team consisted of Professor John Bolton (Institute of Public Care) and the following members of the DU:

- Lynda Chandler (Performance Improvement Manager – Unscheduled Care)
- William Oliver (Performance Improvement Manager)
- Jennifer Morgan (Operational Research and Modelling Development Manager)
- Emrhys Pickup (Information Analyst)
- Julie Townsend (Advanced Information Analyst)

An Advisory Group was established to help guide the project and provide critical friend challenge.

The Advisory Group was comprised of representation from the National Programme for Primary Care and Welsh Government policy and professional leads for:

- NHS Delivery & Performance
- Social Services and Integration
- Health, Social Services and Population Statistics
- Healthcare Science and Allied Health Professionals
- Office of Chief Nursing Officer.

In the course of the Project, links were also made with the NHS Wales Informatics Service (NWIS) and the Welsh Community Care Information System (WCCIS).

Stage 1 of the Project

The DU's Analysis Team utilised data from the Patient Episode Database of Wales (PEDW) to populate the (Admitted to Hospital) red box of the original model in order to reflect what each health and social care system might expect in terms of potential demand. The data was patients aged 65 and over admitted to acute hospital either as an elective or emergency admission (see **Appendix 3** for specification).

The purpose of this stage was not to create a dataset or to undertake a data collection exercise. Where possible, data was drawn systematically from existing sources. Stage 1 data provided a template of the model and gap analysis that informed on the data requirements of the other stages of the project and further work.

Stage 2

In March 2019 each Regional Partnership Board (RPB) was approached by the DU to take part in the Project. All RPBs responded positively and preparatory meetings were held in every region between March and September, in which the model and outline project plan were explained.

The West Wales and Cwm Taf Morgannwg RPBs agreed to pilot the process, and those pilots were completed in July and August 2019 respectively.

The Project Team is grateful to those RPBs for their participation and willingness to share the learning.

Stage 3

In Stage 3, the learning from the pilot sites was rolled out to the rest of the Welsh RPBs.

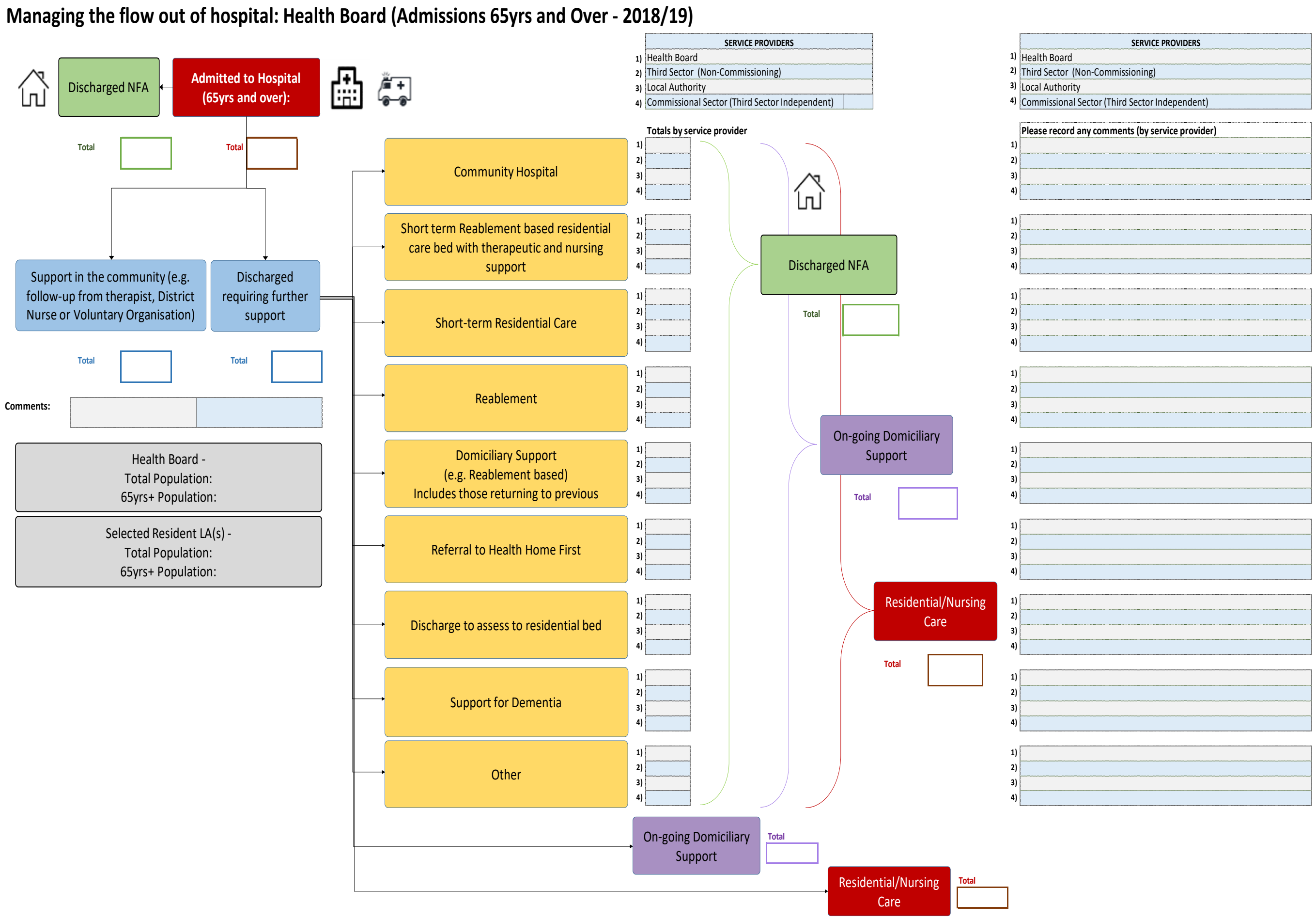
It had become evident from the pilot sites that the system in Wales is currently more complex than that depicted in the original model (**Diagram 1**), and the partnerships required a mechanism of data capture to reflect this.

The DU Analytical Team therefore worked with partners in each region to develop a tailored template to reflect their specific services and pathways. This pragmatic approach was taken to ensure that the data was meaningful and owned by each RPB.

Whilst all the RPBs provided services with the same core functions, each area (even within RPBs) attribute them with different names. This is illustrated in **Appendix 4.**

The template was also adapted to accommodate the fact that, despite policy and good practice stating that no one should be assessed for long term care whilst in an acute hospital bed, there are still a substantial number of older people for whom this occurs in Wales. The final iteration of the template is inserted as **Diagram 2** below**.**

Diagram 2: Data Collection Template



The Project Team provided support on request, throughout the data collection process, which took between 1 and 3 months in each RPB, with the last submitting their data in January 2020.

At the end of the data collection process a “So What?” workshop was held with the RPB to bring together the data submitted, and to consider the following questions:

- Could you count your older people who needed care and support post hospital admission?
- Were you able to track your patients through the care system and discover the outcomes achieved?
- What problems did this exercise pose for you and how did you/will you overcome these?

- Does the information gathered support or challenge your current plans, including IMTPs/ICF & Transformation Fund bids?
- Are there any changes/adaptations you want to make in light of this information?
- What learning from the project do you intend to sustain going forward?

Data Specification

Source: Patient Episode Database Wales (PEDW)

Admissions to Hospital

- Data period - Financial year 2018/19
- Based on patients resident to the Health Boards and Local Authorities
- Patients aged 65yrs plus
- Admission method to include Emergency and Electives
- Admissions to Acute Hospitals only
- Patient classification to include Inpatient Ordinary Admissions
- Patients treatment to exclude Mental Health (7** treatment Specialty codes removed)
- The hospital spell admitting episode (Number '01')

Source: Stats Wales

Population figures

- Population figures obtained from StatsWales for Mid 2017

https://statswales.gov.wales/Catalogue/Population-and-Migration/Population/Estimates/Local-Health-Boards/populationestimates-by-lhb-age

https://statswales.gov.wales/Catalogue/Population-and-Migration/Population/Estimates/Local-Authority/populationestimates-by-localauthority-year

APPENDIX 4

Intermediate Care Service List

Bedded Services

Accommodation Solutions

Community Hospital

Discharge to Assess Extended Stay residential Bed (max 6 weeks)

Discharge to Assess to residential Bed (LOS tbc)

Residential or nursing care placement

Discharge with referral to Rapid Response Services

Hospice

Nursing Care Home

Reablement based - Residential care

Short Term beds (chargeable)

Short Term Nursing

Short Term reablement based residential care bed with therapeutic and nursing support

Short term residential care

Step down from acute

Step down service admissions

Supported Accommodation

Temporary Residential /Respite

Step Down Services - Community Hospital

Bedded & Non-bedded services

Acute Response Team (ART)

Respite

Support for Dimentia

Single Point of Access

Palliative care

Non-Bedded Services

Acute Clinical Team

Day Care

Direct Payment/Support Budget

Discharged with a live in service provision

Discharged with a sitting service incl. respite

Discharge with assistive Technology or other equipment

Discharge with referral to reablement & Falls Service

Domicillary Care

Domicillary Support (Incl. Extra Care & Home Care)

Domicillary Support (e.g. reablementbased) includes those returning to previous packages

Domicillary/Day care

Referrals into social care elemnet of CRT/direct to bridging (i.e. no input from helath therapies)

Full Team reablement CRT

Get Me Home+

IRS

Nutrition and Dietetics

Other

Other Teams

Rapid Homecare

Reablement

Reablement as Primary/Secondary teams

Reablement domicillary Support

Referral to Health Home First

Extra care housing

StayWell@Home

Stroke Pathway

Support@Home

CRT Therapy only/Full Team

Technology pathway

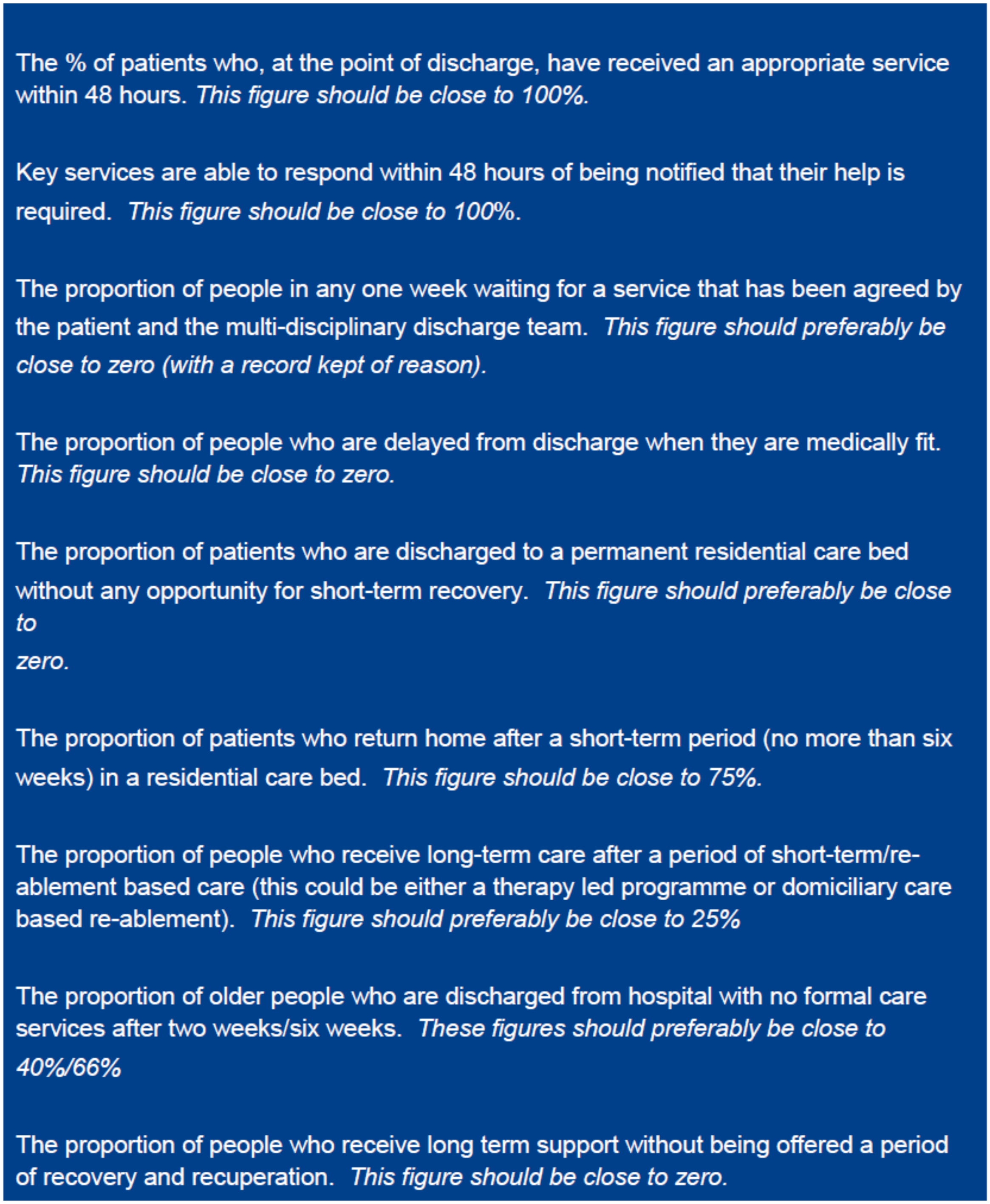
Telecare

Therapy only reablement CRT

APPENDIX 5

Proposed Performance Measures

Copied from Page 20, 'Reducing delays in transfers of care for older people'
https://ipc.brookes.ac.uk/publications/pdf/Some_key_messages_around_hospital_transfers_of_care.pdf



The % of patients who, at the point of discharge, have received an appropriate service within 48 hours. *This figure should be close to 100%.*

Key services are able to respond within 48 hours of being notified that their help is required. *This figure should be close to 100%.*

The proportion of people in any one week waiting for a service that has been agreed by the patient and the multi-disciplinary discharge team. *This figure should preferably be close to zero (with a record kept of reason).*

The proportion of people who are delayed from discharge when they are medically fit. *This figure should be close to zero.*

The proportion of patients who are discharged to a permanent residential care bed without any opportunity for short-term recovery. *This figure should preferably be close to zero.*

The proportion of patients who return home after a short-term period (no more than six weeks) in a residential care bed. *This figure should be close to 75%.*

The proportion of people who receive long-term care after a period of short-term/re-ablement based care (this could be either a therapy led programme or domiciliary care based re-ablement). *This figure should preferably be close to 25%*

The proportion of older people who are discharged from hospital with no formal care services after two weeks/six weeks. *These figures should preferably be close to 40%/66%*

The proportion of people who receive long term support without being offered a period of recovery and recuperation. *This figure should be close to zero.*

CLlLC
WLGA

WLGA response to the Inquiry on the role of local authorities in supporting hospital discharge

February 2025

About Us

The Welsh Local Government Association (WLGA) represents the 22 local authorities in Wales, and the three national park authorities and the three fire and rescue authorities are associate members.

The WLGA is a politically led cross-party organisation, with the leaders from all local authorities determining policy through the Executive Board and the wider WLGA Council. The WLGA also appoints senior members as Spokespersons and Deputy Spokespersons to provide a national lead on policy matters on behalf of local government.

The WLGA works closely with and is often advised by professional advisors and professional associations from local government, however, the WLGA is the representative body for local government and provides the collective, political voice of local government in Wales.

Introduction

Councils, care providers and wider health services continue to do all they can to enable people to be discharged from hospital and back to their homes with the correct support as soon as they can, as well as focussing on preventing hospital admissions in the first place. This has involved increasing community care capacity, developing extra step-down beds and community care packages, helping people get care closer to home and free up hospital beds. This has highlighted the benefits of councils and health working in partnership with a shared endeavour to deliver tangible benefits and positive impacts for individuals. But it also comes with a need to invest significant amounts of time and resource, including additional funding, to support this work. It also highlights the importance of developing future models of community-based care which take a 'whole-person' approach, addressing people's physical health, mental health and social needs together, a direction of travel supported by local government's 'Vision for Social Care in Wales'[1].

Despite these efforts, challenges persist in consistently achieving timely and efficient discharges. The pressures on social care services, including limited funding, workforce shortages, and increasing demand are a contributory factor to this, but it is important to acknowledge that there are a range of other factors that extend beyond social care that lead to individuals being admitted to hospital and, in some cases, delayed pathways of care from

---

[1] Download.aspx (wlga.wales)

hospital. Such delays can also result from a range of other factors, including patients waiting for nursing assessments, Continuing Health Care (CHC) assessments, delays in completion of medical and psychiatric assessments and the time taken for medicines management arrangements to be finalised, as well as the need for small adaptations to be undertaken.

Given the level of focus that has been placed on pathway of care delays in recent times, alongside a narrative that seemingly puts the root cause of these delays at the feet of social care we welcome the opportunity to respond to the Local Government and Housing Committee’s Inquiry into this area.

Current Pressures

When looking at the role that local authorities play in supporting hospital discharges and addressing delayed pathways of care it is important to acknowledge the context within which both social care and wider council services are operating. Councils remain deeply concerned about the ongoing pressures facing social care. WLGA’s annual budget survey of councils demonstrates that councils are facing additional *in-year* pressures amounting to £238m for 2024-25, £106m (45%) of which is attributable to social services pressures and builds on a £107m social services overspend in 2023-24.

In 2025-26 local authorities will face an estimated pressure of £559m of which £223m is as a result of social services pressure. This represents a 9% increase on current budgets and is 40% of the overall local government pressure. Despite our ambition and vision for social services, it should be noted that these financial pressures are just to ‘stand still’ and do not factor in the potential impact of changes to National Insurance contributions announced at the end of 2024.

These pressures are despite councils spending over and beyond the funding allocated by Welsh Government for social care services. Councils hold significant concerns that without further funding, meeting care and support needs will become increasingly difficult with a potential knock-on impact for our NHS and health care services, leaving people waiting longer for care in the community affecting their well-being and quality of life.

The WLGA budget survey highlighted the continued impact of growing demographic challenges, the rising cost of living, workforce shortages, and inflation across the entire social care system. Additionally, new responsibilities and legislation are being introduced without appropriate levels of funding attached. Increasing demand for services, combined with greater complexity of care and support needs, further intensifies these challenges. As a result, budgets are being stretched, recruitment and retention of staff remain significant challenges, there are increasing concerns about councils’ ability to meet all care and support needs and families and unpaid carers are placed under even greater strain.

The survey also highlighted that at the same time a lack of capacity, resources and clarity of financial responsibilities in health also has implications for local authorities. Additional costs have been identified by at least one council linked to discharges from hospital where the individual is not ready for discharge and there is no rehabilitation package in place from health, so costs have had to be picked up by social care and the social services budget. Significant concerns were also raised in relation to both Continuing Healthcare Care (CHC) and Funded Nursing Care (FNC). Councils reported that the level of FNC provided is not enough to fully cover the cost, with care homes unable to cope with the FNC contribution from health that is made. It was also highlighted that CHC discussions can be extremely challenging. This means that costs are often passed on from the NHS onto local authorities, essentially meaning that councils are having to subsidise health care, often at a significant cost.

For many, social services is the area of greatest risk to council's budgets where pressures are most acutely seen. While councils continue to mitigate these pressures through the use of other areas of savings delivery, slippage and increased income many of these will be of a one-off nature leaving councils with recurrent pressures that impact on future years budget planning.

The WLGA continues to seek regular feedback from councils on the issues and concerns they are facing at the local level in delivering social care services. While the level to which specific issues are impacting locally can vary, all have highlighted concerns and challenges which reflect common pressures being experienced across both adult and children's services. These include:

Workforce: There continue to be significant challenges in relation to recruitment and retention both for in-house (including assessment and provision) and commissioned services. This issue has been exacerbated by number of issues including:

- Competition both from the health service and other sectors who can offer better terms and conditions.
- A reduction in staff prepared to continue to work in the sector, with some making lifestyle choices to reduce working hours and many leaving the sector because they are exhausted.
- Some have felt let down by the lack of recognition given to social care workers, with NHS workers seemingly more valued
- Increasing demand and pressure being placed on an under-valued and over-stretched workforce

Care at Home: Both in-house and commissioned services are under significant pressure, with demand for services increasing which has a wider impact on reablement provision, hospital discharges, prevention of admissions and responding to urgent need.

Waiting lists: Waiting lists have been increasing, people waiting for packages of care and for people awaiting assessment and/or equipment and support from occupational therapists. This also impacts on unpaid carers well-being as there are delays to provision of equipment and training/support to meet their cared for's needs

Unpaid Carers: There are increasing concerns for unpaid carers who have continued under severe pressure. While carer's services have continued to support people, there has been an increase in demand, with concerns that if unpaid carers are unable to continue to care effectively, then there will be increased demand for support placed on already overstretched services.

The reality is that despite councils' best efforts, financial pressures are impacting the range, scale, and quality of services able to be offered to local communities.

Recent winter periods have seen greater collaboration across services and organisations in support of improved flow of individuals using care and support through the hospital system and transferring to care in the community. For example, most local authorities have integrated nursing or intermediate care teams working in the community to 'pull' patients out of hospital back to their home or community, furnished with appropriate level of support they need to be re-abled and live as independently as possible.

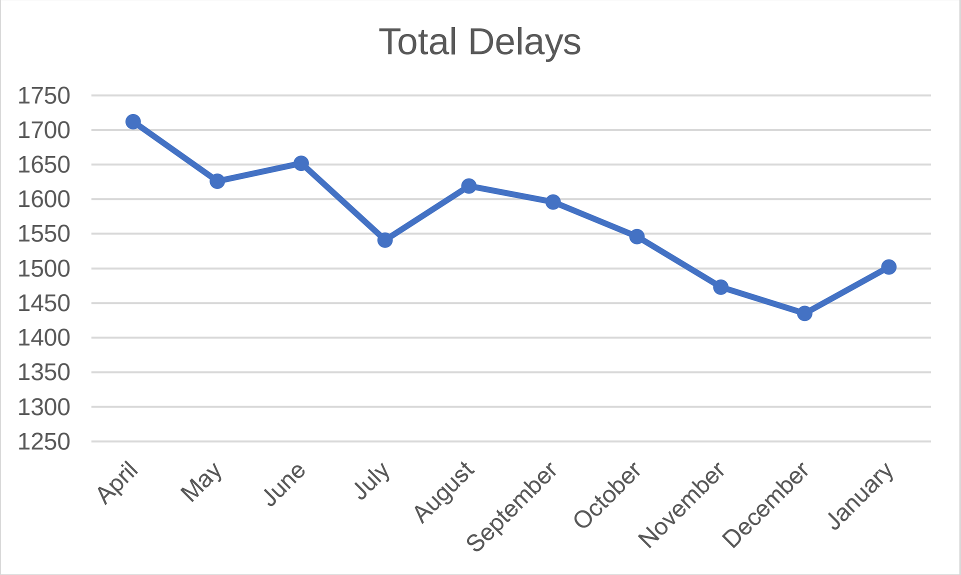
While progress continues across the regions in Wales, there have been a number of trends consistently reported by local authorities in relation to unscheduled pressures in previous years; many of which have been exacerbated by the demands placed on the health and social care system. These include:

- The fragility in domiciliary care and reablement services, exacerbated by market capacity, volatility in demand and short-term problems, associated with sickness or leave at times of public holiday.
- Responsiveness and complexity of service required are significant issues, with workforce recruitment and retention providing significant challenges.
- Capacity in traditional residential care had been relatively resilient, but a number of areas have reported a scarcity of specialist EMI and nursing care capacity (in part as a result of workforce issues and with a particular challenge with recruitment of nurses).
- Pressures on the hospital system, in particular increased admissions and people presenting with higher levels of acuity, coupled with the reduction of hospital beds.

Recent Data

Like the NHS in other parts of the UK the NHS in Wales is experiencing persistently high levels of pathways of care delays which negatively impact on people's long-term health and the "flow" through the wider health and care system. This has been an area of focus for some time and councils have worked hard to support health in reducing these delayed discharges, with the most recent figures demonstrating the progress that has been made by councils in helping to reduce these delays.

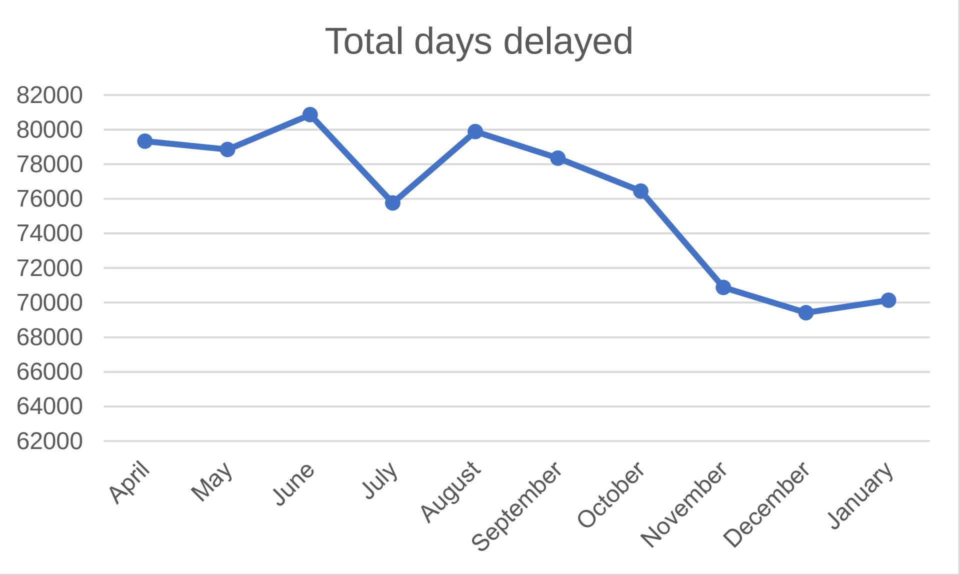
The latest figures[2] show that since April 2024 there has been a downward trend in the number of hospital discharge delays, with a 12% reduction in delays since April 2024, despite a recent increase in January 2025.



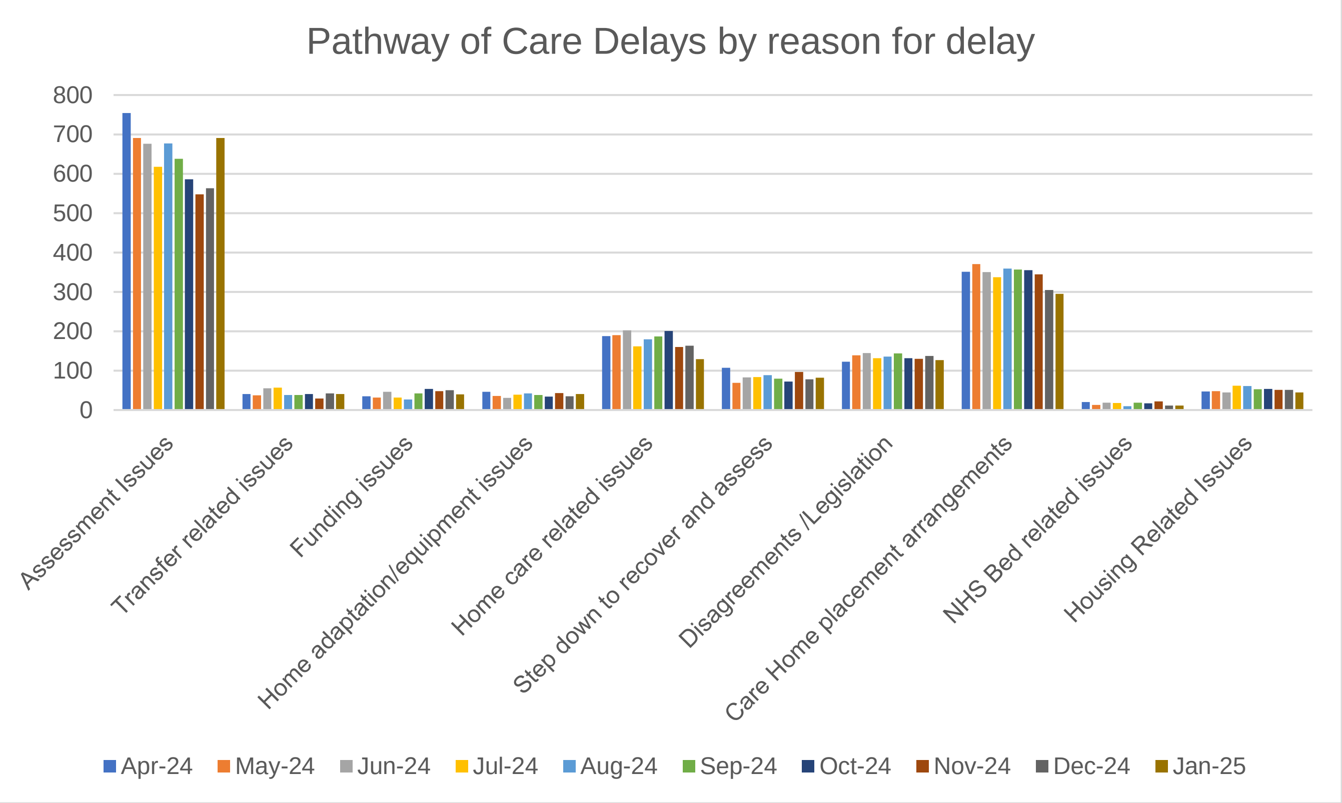
---

[2] Pathway of Care Delays by reason for delay and date

Similarly, this downward trend has been seen in the total days delayed seen over the same period of time, with a 12% reduction:



The chart below demonstrates the reasons behind the delays:



It can be seen that while assessment issues is the biggest single reason for delays there are a number of other reasons for why there are delays to pathways of care. There have been significant reductions in recent months in the number of delays due to assessment issues, with a 25% reduction in assessment delays between April and December 2024. January saw an increase in delays as result of assessment issues but the winter months often see a surge in healthcare demand due to seasonal illnesses, leading to heightened demand and increased hospital admissions.

During the period April 2024 to January 2025 of note, delays related to:

- Home care reduced from 188 to 129 (31%)
- Care home placement arrangements reduced from 351 to 295 (16%)
- Awaiting social worker allocation reduced from 130 to 113 (13%)

This goes some way to demonstrating the impact of the work and resources that councils have put in to supporting hospital discharges and reducing delays.

It is also important to recognise that social care continues to support a significant number of people in the community at the same time, which prevent hospital admission in the first place. This far outweighs the number of delays in hospital discharges, which reflects that prevention and early intervention services play a critical role in reducing pressures in secondary care services. Since January 2024, councils have supported:

- a 47% reduction in those waiting for domiciliary care (reducing from 1055 to 554)
- a 36% increase in those receiving reablement (increasing from 1,113 to 1,519)
- An increase of adults in receipt of domiciliary care (increasing from 17,012 to 17,757)
- an increase in those receiving long term care home accommodation (increasing from 13,262 to 13,380)

From the data it can be seen that councils have made progress in reducing hospital discharge delays in part as a result of investing in assessment processes and social care services. Reductions in home care and care home placement delays demonstrates the commitment of councils and social care to streamlining discharge processes and ensuring timely support for individuals leaving hospital.

Beyond hospital discharge, local authorities continue to play a crucial role in preventing hospital admissions through early intervention and community-based care. The significant reductions in those waiting for domiciliary care, while those accessing reablement services have continued to increase, means more individuals regain independence at home. Additionally, more adults are now receiving domiciliary care and long-term care home placements, ensuring sustained support for those with complex needs. These figures highlight the extensive efforts of local authorities in delivering social care, not only to ease hospital pressures but also to enhance community-based support that keeps people well and independent for longer.

The infographic below further demonstrates some of the levels of demand that continue to be met by councils:

Social Services Contacts

416,040 contacts received by statutory social services for adults, carers and children. This equates to **1,139 contacts every day**.

Assessments

135,110 new assessments were undertaken across both adults and children's services. This equates to **over 370 new assessments undertaken every day.**

Care and Support

On 31 March **76,315 people** (adults, children and carers) had a care and support plan in place.

Source: StatsWales[3]

These figures go some way to demonstrating the number of people supported by social services teams every day, with well over 1,000 people making contact with social services daily. Of the 370 new assessments undertaken every day over 4 in 5 of these (82%) lead to that individual's needs needing to be met, either through a care and support plan or by other means. Compared with the previous year there has been a 13% increase in the number of contacts made to social service and a 7% increase in the number of new assessments undertaken. By way of example, one council has reported that they have experienced a 15% increase in demand across all client groups in Adult Services in the last year.

The focus on hospital discharge has placed significant pressure on social care services, affecting their ability to deliver wider community-based support. While councils have made progress in reducing delays and expanding domiciliary and reablement services this has often come at the expense of other key areas of social care. With resources and staffing redirected to prioritising hospital discharges, services such as preventative care, early intervention, and long-term support for vulnerable individuals have faced increasing strain.

This shift can create a ripple effect, where fewer resources are available for preventing hospital admissions in the first place, leading to greater long-term demand for both health and social care. For example, while domiciliary care waiting lists have been reduced councils must also ensure they continue to support those who rely on ongoing community care to maintain their independence. Similarly, increasing care home placements may ease immediate hospital

---

[3] Available at https://statswales.gov.wales/Catalogue/Health-and-Social-Care/Social-Services/social-services-performance-and-improvement-framework. Data covers 2022-23

pressures, but it can limit the ability to provide alternative, home-based support that many individuals prefer.

A balanced approach is essential, while hospital discharge is a priority, social care must also have the capacity to deliver preventative and ongoing support. Without this, pressures on hospitals may ease in the short term, but demand for crisis interventions could increase, making the system less sustainable in the long run.

Actions Taken

In responding to these challenges, councils and health boards are meeting regularly to review cases and address barriers on a person-centred level. Each council is aware of the cases within its own boundary and working with the health board to maintain an overview.

A range of positive interventions have been put in place to improve flow through the system, both by councils, health boards and by working together. This includes new ways of working and further investment in capacity and continued efforts to recruit more staff. There are a range of excellent examples of good practice to highlight, including:

Step Up/Step Down Beds – Short-term accommodation for individuals transitioning between hospital and home, preventing unnecessary admissions and enabling timely discharge. For example, creating additional bedded capacity to provide step-down and community step-up (avoiding hospital admissions) beds in internal residential provision.

Trusted Assessors - utilising and further developing trusted assessor models to support timely assessment and avoid delays and duplication. For example, using Community Occupational Therapists' as trusted assessors for care and support assessments as opposed to Social Workers, utilising staff at the right level in the right place. And using Community Resource Team (CRT) home care assessors, as trusted assessors to prescribe care, where a person cannot meet their full reablement outcomes, releasing the need for Social Worker assessment following CRT.

Intermediate Care Teams and Rapid Response Teams - ensuring the provision of co-ordinated services across health and social care

Discharge to Recover and Assess (D2RA) – Allows patients to leave hospital while their ongoing care needs are assessed in a more appropriate setting, reducing hospital stays. There are examples of councils: establishing a rapid response domiciliary care service to help people return home and have their ongoing needs assessed in a more appropriate setting than the hospital; and enabling rapid access to a temporary residential or nursing care placement for services users with a higher level of need, while their future requirements are fully assessed.

Extension of services - Extending the range of rehabilitation/reablement services, including the use of intermediate care flats as part of a wider health, social care and community complex.

Home First Service - Local authorities utilising their Home First Service to provide preventative / discharge at the front door of their acute hospitals.

Integrated Community Networks - provide rapid access to multi-disciplinary proactive care in the community following referrals including WAST emergency calls, with the aim of reducing hospital conveyances and admissions.

Integrated Prevention Service (IPS) - which provides short term Occupational Therapy support working closely with the reablement and prevention services teams to support with admission avoidance or safe and timely discharge from hospital and enabling those citizens who are able, to continue to do things for themselves.

Single Points of Access (SPOA) – A streamlined entry point to social care services, ensuring quick assessments and coordinated support for discharged patients.

Micro-Care Initiatives – Encouraging small, independent care providers to offer flexible, local home care, easing the burden on larger care services.

Home Support and Assistive Technology – Digital solutions, such as remote monitoring devices, GPS trackers, and automated reminders, supporting independent living and reducing hospital readmissions.

Wellbeing Hubs and Community Connectors – Providing practical and emotional support to individuals post-discharge, reducing isolation and promoting recovery.

Integrated Working – Establishing integrated discharge boards to identify potential issues around discharge and how they will be resolved. Other councils continue the development of locality teams with dedicated roles around key areas of activity such as hospital discharge, Continuing HealthCare (CHC) assessments and carers.

Joint Working - Social care and third sector staff working alongside health staff in hospital to prevent delayed discharges.

These initiatives aim to create a more integrated and community-based approach to hospital discharge, ensuring that people receive the right care at the right time while easing pressure on hospitals and long-term care services.

Care Action Committee:
Local government has also been key members of the Care Action Committee (CAC). Originally established in 2022 the CAC chaired by the then Minister for Health and Social Care met regularly during the 2022/23 winter period. The Committee’s membership included the WLGA Leader, Chief Executive and Health and Social Care Spokespersons, along with local authority Chief Executive and Director of Social Services representatives, and health colleagues.

The CAC oversaw the work undertaken across health and social care that had an ambition of providing an additional 1,000 beds or equivalent community services for winter of that year to ease system pressure and reduce anticipated delayed discharges. Whilst the ambition to deliver 1,000 beds was not achieved, over 670 beds or equivalents were. Councils worked closely with partners in health and the Welsh Government to deliver these. These innovative packages helped to build move-on capacity and improve flow across the health and social care system and to free some of the areas under pressures, such as discharges from hospitals and the impact this can have on ambulance waiting lists and admittance to hospitals.

This increased capacity in the community demonstrates the benefits of councils and health working in partnership with a shared endeavour to deliver tangible benefits and positive impacts for individuals but also comes with a need to invest significant amounts of time and resource to support this work.

Building on this work Welsh Government set out their mission, consistent with *'A Healthier Wales'* to develop an integrated community care system for Wales through their Statement of Intent document, *'Building Capacity through Community Care – Further Faster'*. Then in September 2023 the Minister for Health and Social Services re-established the CAC to oversee the work around increasing health and social care service resilience and develop a more integrated system outlined in *'Further Faster'*.

In October 2023, the CAC agreed to focus on three key priorities for winter 2023/24:

- Reduction in pathways of care delays due to assessment
- Increased weekend capacity for district nursing and palliative care nursing; and
- Increased community capacity to support step up/down of support, such as, Enhanced Community Care (ECC)

It has since been agreed to continue focussing on these same priorities for Winter 2024/25, with membership of the CAC being extended out to include Regional Local Authority Elected Member Representatives, alongside Regional Senior Accountable Officers who are responsible for providing local interpretation of the current state and actions that are in progress against the priorities.

While councils remain committed to improving the discharge processes through the work of the Committee and welcome the extension of membership to include additional elected members it is critical that the focus of the work is not just on social care. It is also vital that we do not just work in partnership at the point of discharge of individuals from hospital, but that there is also a focus on preventing people from entering hospital in the first instance.

There remains a narrative, which is often painted in the media, that implies that social care exists solely to ease pressure on the NHS and is failing to do its job. Many people rely on social care to support them to live independent and fulfilling lives and the continual focus on supporting the NHS, important though it is, places these vital services at risk. There is a need for a strategic approach to the pressure on hospital beds which requires a much broader range of actions to prevent admission, streamline discharge for those that do not need social care or other support and focus on capacity to support recovery and reablement.

Despite the examples of good practice and the work of the CAC, the real difficulties in addressing the challenges presented is the capacity of the organisations and resources available. Given the ever-growing pressure on services and the impact of cuts seen in previous years, particularly to local authority budgets, this will continue to be an issue. There is a need to fully acknowledge the significant pressures being faced by councils and ensure they are funded appropriately to meet these pressures.

Conclusion

The WLGA recognises the challenges posed by hospital discharge delays and the pressures this places on both the NHS and social care services. However, it must be stressed that these delays are a result of complex, systemic issues that require joint solutions rather than placing disproportionate blame on social care.

Local authorities in Wales are working tirelessly to support individuals in their transition from hospital to appropriate care settings. However, the significant increase in demand for social care, combined with workforce shortages and financial constraints, has created substantial pressures on our services. Care providers face difficulties in recruiting and retaining staff, and the availability of home care packages or residential placements is impacted by these national workforce challenges. Without adequate funding and support, it is simply not possible to scale up social care provision at the pace required to meet rising demand.

It is also essential to acknowledge that delays in discharge are often caused by a range of factors beyond social care. Many individuals require further medical treatment, rehabilitation, or complex assessments before they can be safely discharged, with other individuals exercising their right to choice and choose not to take up care home placements or other services. The integration of health and social care remains a priority, and local authorities continue to work closely with NHS partners to ensure that discharge pathways are as efficient as possible.

The WLGA urges the Welsh Government to invest in both health and social care, treating both with parity, to create a system that is truly integrated, properly resourced, and sustainable for the future. Local government remains committed to overcoming these challenges, but a whole-system approach is needed to ensure that individuals receive the right care, at the right time, in the right place.

Senedd Cymru Local Government and Housing Committee: Inquiry into the role of Local Authorities in supporting hospital discharges

Contribution by ADSS Cymru

Authority	Lance Carver – Cadeirydd, ADSS Cymru Jason Bennett – Chair, All Wales Adult Services Heads (AWASH)
Completed by	Paul Pavia, Policy and Research Lead
Date	February 2025

General Comment

The Association of Directors of Social Services (ADSS) Cymru is the professional and strategic leadership organisation for social services in Wales and is composed of statutory directors of social services, the All-Wales Heads of Children's Service (AWHOCs), the All-Wales Adult Service Heads (AWASH) and tier three managers who support them in delivering statutory responsibilities: a group which consists of over 300 social services leaders across the 22 local authorities in Wales.

The role of ADSS Cymru is to represent the collective, authoritative voice of senior social care leaders who support vulnerable adults and children, their families, and communities, on a range of national and regional issues in relation to social care policy, practice, and resourcing. It is the only national body that articulates the view of those professionals who lead our social care services.

As a member-led organisation, ADSS Cymru is committed to using the wealth of its members' experience and expertise. We work in partnership with a wide range of partners and stakeholders to influence the important strategic decisions around the development of health, social care, and public service delivery. Ultimately, our aim is to benefit the people our services support and the people who work within those services.

Foreword

ADSS Cymru welcomes the opportunity to contribute to this Senedd inquiry. We also gave extensive evidence to the Health and Social Care Committee's inquiry into Hospital discharge and its impact on patient flow through hospitals, which reported in the summer of 2022.[1]

However, we believe that the terms of reference for this inquiry reflect an overly narrow perspective on the issue, one that prioritises hospital processes over the fundamental goal of enabling individuals to live well within their communities. Put simply we believe that there should be a greater emphasis on patient outcomes rather than patient flow.

The inquiry's framework positions local authorities - primarily social services - as responsible for ensuring hospital efficiency rather than as partners in a broader system designed to support people in living independently. This approach does not fully recognise the statutory role of local authorities, as set out in the Social Services and Wellbeing (Wales) Act 2014, which is to promote the wellbeing of individuals and ensure they receive the right care and support within the most

---

[1] ADSS Cymru/WLGA, *Senedd Cymru Health and Social Care Committee: Inquiry into hospital discharge and its impact on patient flow through hospital*, 2022.

appropriate setting. The term “hospital discharge” itself is not recognised in this legislative framework. Instead, social services are tasked with supporting people to live safely at home, reducing the need for hospital admission and ensuring timely, well-planned transitions back into the community.

We think it would be of greater benefit to examine the effectiveness of hospitals, community health services, and local authorities in working together to support individuals to remain at home, return home, and avoid unnecessary hospital admissions. The focus should not solely be on the logistics of hospital discharge, but on the extent to which the entire health and social care system is structured to deliver outcomes that align with the needs and aspirations of individuals and communities.

Moreover, the challenges identified in the inquiry’s terms of reference must be considered in the context of systemic factors that shape the ability of local authorities to provide support. Workforce shortages, delays in assessments, and difficulties in arranging care provision are not just obstacles to discharge but are reflective of broader pressures within the social care sector. These pressures are exacerbated by a lack of parity in terms and conditions between the social care and health workforce, inconsistencies in community investment, and the continued challenge of ensuring integrated, person-centred care. Investment in community-based services and early intervention is key to reducing unnecessary hospital admissions and facilitating sustainable care pathways. Social Services departments spend increasing sums supporting more and more people to live in their communities.

In submitting this evidence, ADSS Cymru respectfully suggests the Committee reconsider the framing of this inquiry, ensuring that the debate centres on how the whole system - NHS, local authorities, and community partners - can collaborate using strengths-based approaches to uphold the principles of person-centred care and independent living. We believe this would help to move beyond short-term fixes towards a genuinely integrated approach that serves the best interests of individuals, families, and communities across Wales.

Introduction

Delays in hospital discharge and timely transfer of care to other secondary providers, primary care and community care, have a significant impact on people in receipt of care their families and carers. It also impacts on citizens requiring admission into hospital, so therefore, discharge and transfer of care planning and its effective implementation is everyone’s business. Multi-Disciplinary Teams (MDT) at both ends of the system, are critical to its successful delivery.

Over the past decades, there has been a great deal of work to both understand the issues and causes of delayed pathways of care and poor patient flows, along with tools and resources to address these. We should consider a delayed pathway as of a symptom of wider challenges in the integrated health and social care support for our citizens.

The varying complexity of delayed pathways require effective partnership working by health and social care organisations, as well as third sector and independent providers. Moreover, in line with the Social Services and Well-being (Wales) Act 2014 and the Principles of Prudent Healthcare, joint working should be driven by the voice of individuals and carers and what matters to them, not just professionals. It is pivotal that the principles of co-production are at the centre of arranging and providing care because supporting people to safely transfer from one setting to the next needs a person-centred, whole systems approach, with agreed joint protocols and practices to achieve the best outcomes.

Therefore, a delayed discharge can be an indication of both service pressures and/or ineffective collaboration in terms of planning, commissioning, and delivery, contributing to systemic failure. The situation is further complicated by the design of services that position the hospital as the ultimate fallback care option, resulting in a tendency for everything to gravitate towards the hospital. This strategy not only depletes community resources but also intensifies the difficulties encountered by both social care and the NHS.

Given that this is such a complex issue, we strongly believe that in pursuing a whole systems approach in the planning, commissioning and delivery of health and care services, to fixate on this one area in isolation would be to miss the point. Fundamentally, we need to ensure we are shifting our focus from secondary hospital-based care to supporting independence, wellbeing and preventative care in the community as articulated in *A Healthier Wales,* as well as the local government's *'Vision for Social Care'.*[2]

This submission will consider a number of issues surrounding the misconceptions that social services delayed discharges are the major contributing factor when considering the lack of available hospital beds in Wales. There is no doubt that social care has a role in supporting people to return home when well enough to do so, but rhetoric that attributes all the issues to this one singular area are inaccurate and unhelpful.

We will explore:

- What is meant by the term 'delay'?
- How integration has led to a shift of responsibilities
- The whole system context - community activity v hospital discharge
- Demographic changes and increased demand
- Increasing complexity of care needs
- The significant reduction in hospital beds (including mental health and dementia) over last the 15 years
- Avoidable harm and deconditioning in hospitals
- The unfunded costs to local authorities in supporting early discharge / avoiding admissions
- Unacceptable gatekeeping of NHS Continuing Healthcare (CHC)
- Why recording a 'delay' after just 48hrs is unreasonable

What's meant by the term "delay"?

Before the COVID-19 pandemic, the measurement was delayed transfers of care, (DToC) a delay at that point was any person in hospital more than 24 hours after their estimated date of discharge, (EDD). The EDD was an agreed date set by all the professionals on an individualised basis as the likely date the person would have everything in place to be able to go home. This was open to interpretation and therefore lacked some national consistency.

The current system of monitoring "pathways of care" may use some coding and language that is similar to the former DToC but is fundamentally different. Old phraseology like EDD and "medically fit" have been replaced with a new definition of "clinically optimised", which describes a state

---

[2] ADSS Cymru et. al., *A Vision for Social Care*, 2022.

where a person no longer needs the acute medical intervention that a hospital provides and can continue their treatment, recovery and convalescence elsewhere. The monitoring of the pathway of care is intended to assist with process mapping, identification of system wide pressure points, and to consider if the right resources are in place in each of the pathways.

This pathway monitoring has also become a new way of national reporting and people are now reported as a “pathway of care delay” (PoCD) if they have not moved out of hospital within 48hrs of this clinical determination. In many circumstances, the PoCD will be significantly earlier in the person’s recovery than the previous EDD & DToC consideration. It will also, by its very nature, include individuals who are still very unwell / not fully recovered from whatever event led to their need for hospital care.

Support for a person who is unwell or requires rehabilitation is a core function of the NHS. The current system of monitoring pathway delays, expectation of “early supported discharge” for a person still suffering the impact of their illness, “discharge to recover & assess” known as ‘D2RA’, creates an expectation that social care will assume responsibility for individuals who would have previously had NHS care for their treatment and recovery.[3]

However, it should be noted that the primary legislation in Wales has not changed, neither has the core funding allocation to local government to allow for this increased cost. (See cost calculator section).

Primary Legislation

NHS (Wales) Act 2006

Part 1 Promotion and provision of the health service in Wales

(1) The Welsh Ministers must continue the promotion in Wales of a comprehensive health service, designed to secure improvement

a) In the physical and mental health of the people of Wales; and

b) the prevention, diagnosis and treatment of illness*

(2) The Welsh Ministers must for that purpose provide or secure the provision of services in accordance with this Act.

(3) (e) Such other services or facilities for the prevention of illness*, the care of persons suffering from illness and **the aftercare of persons** who have suffered from illness as they consider are appropriate as part of a health service,

(f) Such other services or facilities as are required for the diagnosis and treatment of illness.* [4]

Social Services and Wellbeing (Wales) Act 2014

Section 19 Duty to Assess the needs of people who may need care and support

Section 32 Determination of eligibility (set nationally)

---

[3] NHS Wales Executive, *Six Goals for Urgent and Emergency National Care Programme – Goal 6* (2022).

[4] The term “illness” is defined in Section 206 of the NHS (Wales) Act 2006 and includes any ‘disorder or disability of the mind and any injury or disability requiring medical treatment or nursing’.

Section 34 Duty to meet eligible needs except for those in Section 47

Section 47 Exception for provision of health services

(1) A local authority may not meet a person's needs for care and support (including a carer's needs for support) under sections 35 to 45 by providing or arranging for the provision of a service or facility which is required to be provided under a health enactment, unless doing so would be incidental or ancillary to securing another service or facility for that person under that section.

(2) A local authority may not secure services or facilities for a person under section 15 (Preventative Services)* that are required to be provided under a health enactment, unless doing so would be incidental or ancillary to securing another service or facility for that person under that section. [5]

How integration has led to a shift of responsibilities

As we can see in the previous section, the legislation is very clear in terms of responsibilities for both the NHS and social care. However, we recognise that services which are integrated offer much better outcomes for our residents, and integration is promoted by Welsh Government policy. It makes sense to provide coordinated community services for our citizens.

Nevertheless, the reality of integration in Wales is that in many ways it has become a rationale to shift responsibility from the NHS to social care. Local Authorities are arranging support for people with NHS needs, and care workers are doing more health-related tasks than ever before. This gradual drift of responsibility has come without a change of legislation, meaning that local authorities are often going beyond their statutory duties, as outlined in Section 47 above.

Furthermore, there has been no corresponding change in core funding formulas for local government or NHS services. There has also not been a change of grade for care workers who are often employed on terms and conditions that are significantly below the NHS pay and grading structure, which would evaluate similar roles with similar responsibilities at a much higher level of renumeration.

This shift in responsibility has increased costs for local government, as detailed in our recent submission to the Senedd's Finance Committee during the scrutiny of the Welsh Government's Draft Budget for 2025-26.[6]

Whole system context – community activity vs hospital discharge

As we prefaced both in the foreword and introduction, whilst delays associated with the hospital are important, they should be seen in a whole system context. The number of people in a hospital

---

[5] Under Part 2, Section 15 (Preventive Services) of the Act, there is a very detailed definition of preventative services where it pertains to adults. A local authority must provide or arrange for the provision of a range and level of services which it considers will achieve the purposes in subsection (2) in its area. (2) These purposes are - (a) contributing towards preventing or delaying the development of people's needs for care and support; (b) reducing the needs for care and support of people who have such needs; (d) minimising the effect on disabled people of their disabilities; (e) contributing towards preventing people from suffering abuse or neglect; (i) enabling people to live their lives as independently as possible.

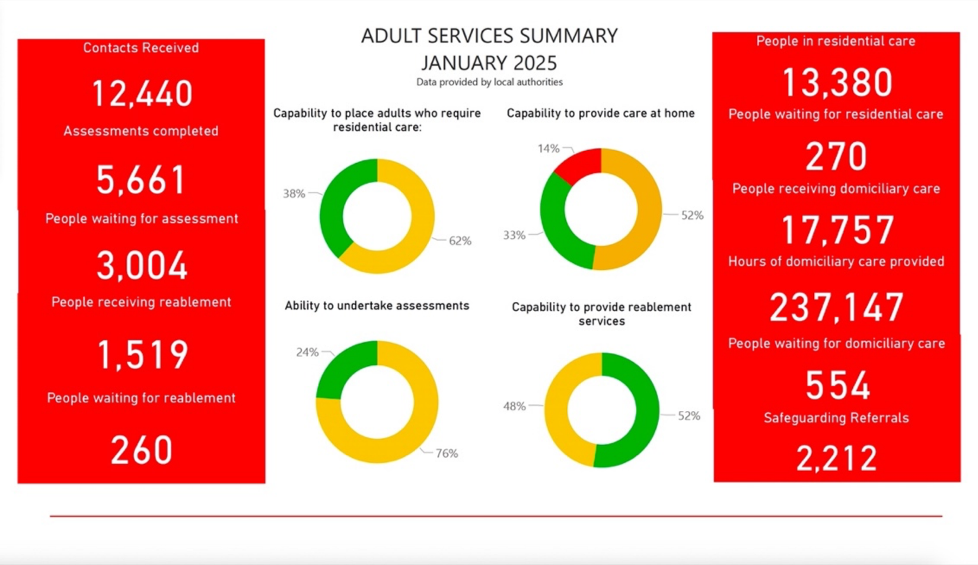
[6] ADSS Cymru/WLGA, *Senedd Cymru Finance Committee: Welsh Government Draft Budget 2025-26* (December 2024).

bed who need social care intervention is a very small proportion of the work of social care. To put this in context, adult social care teams in Wales complete over 70,000 assessments each year.

- **2021-22** - 70,884 assessments[7] with 50,640 care & support plans
- **2022-23** - 74,417 assessments completed with 50,144 care and support plans.[8]

For the purpose of comparison, the following data represents a one-month snapshot obtained from social services checkpoint data. This information, collected by local authorities, is compiled by the Welsh Government to develop a performance monitoring dashboard.

January 2025 Snap-shot



ADULT SERVICES SUMMARY
JANUARY 2025
Data provided by local authorities

Contacts Received
12,440
Assessments completed
5,661
People waiting for assessment
3,004
People receiving reablement
1,519
People waiting for reablement
260

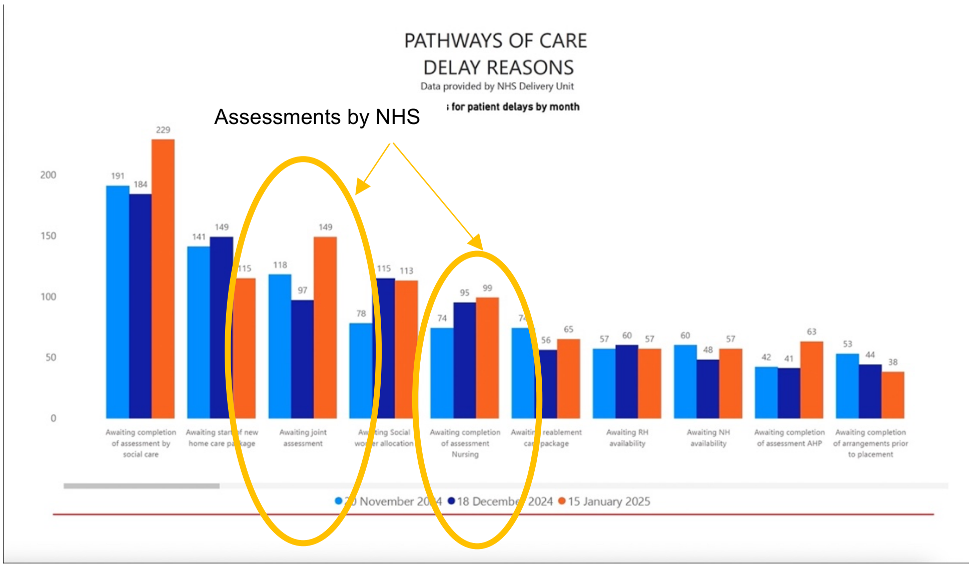
People in residential care
13,380
People waiting for residential care
270
People receiving domiciliary care
17,757
Hours of domiciliary care provided
237,147
People waiting for domiciliary care
554
Safeguarding Referrals
2,212

In January 2025, of the 5,661 completed assessments, only 229 individuals were clinically optimised hospital patients and working with social care to finalise their discharge plans. There were also 113 new hospital referrals awaiting social work allocation.[9]

These figures go some way to demonstrating the number of people supported by social services teams every day, with well over 1,000 people making contact with social services daily. Of the 370 new assessments undertaken every day, over 4 in 5 of these (82%) lead to that individual's needs needing to be met, either through a care and support plan or by other means. Compared with the previous year there has been a 13% increase in the number of contacts made to social service and a 7% increase in the number of new assessments undertaken. By way of example, one council has reported that they have experienced a 15% increase in demand across all client groups in Adult Services in the last year.

---

[7] StatsWales, New assessments completed during the year, by local authority (April, 2024).
[8] StatsWales, Adults with a care and support plan at 31 March, by local authority (April, 2024).
[9] StatsWales, Pathway of care delays by reason for delay and date (February, 2025).



There is often a narrative about assessment delays being "*social care delays*". However, it is important to acknowledge that there are a range of other factors that extend beyond social care. Such delays can also result from issues like patients waiting for nursing assessments, Continuing Health Care (CHC) assessments, delays in completion of medical and psychiatric assessments and the time taken for medicines management arrangements to be finalised. As we can see from the graph above, delays related to assessment for "joint" and "nursing" when combined are higher than those waiting for "*social care*". It should also be noted that a social worker cannot fully complete their assessment until they have consulted with relevant professionals, families and, most importantly, the individual and any advocates they may have supporting them.

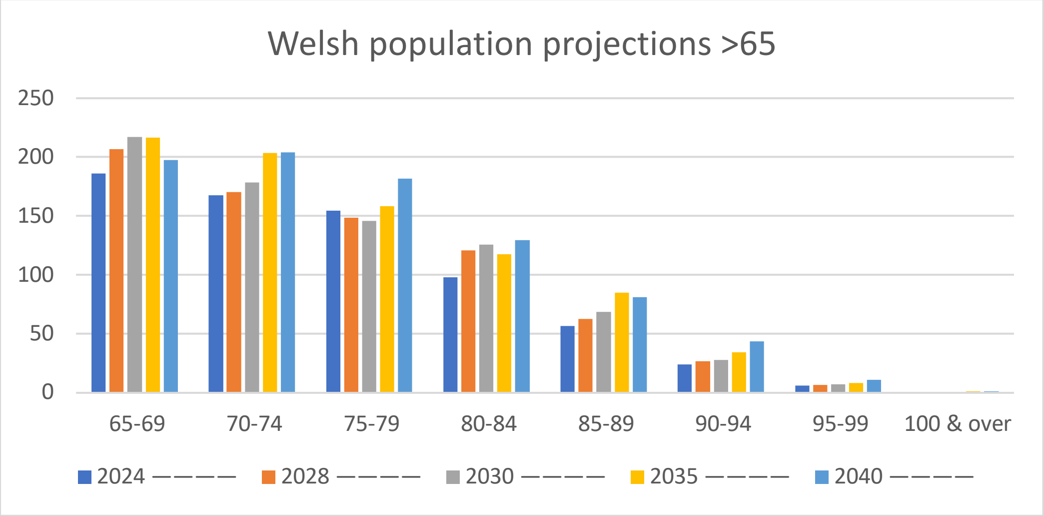
So "awaiting completion of social care assessment" should really be considered as "social worker is actively working with the person, the MDT and family". An assessment is not a "tick box" quick conversation. Rather, it is a detailed, skilled professional interaction with the individual and other relevant parties to formulate and agreed plan of care and support for those people with eligible needs. Social workers are highly skilled, trained professionals and whilst initiatives like "trusted assessor" can support non-complex arrangements, there will always be a cohort of people who need this specialist intervention. We have provided an insight from a social worker in Annex 2, which sets this out in more detail.

Demographic changes and increased demand

Demographic data indicates an increasing older population in Wales, which is positive for the majority of our population. The Office of National Statistics data shows that mid-2022 there were 1.7 million people aged 85 years and over, making up 2.5% of the population. By mid-2047, this is projected to have nearly doubled to 3.3 million, representing 4.3% of the total UK population. There are projected to be many more people at older ages by 2047, in part because of larger cohorts from the 1960s now being aged over 80 years, as well as general increases in life expectancy.[10]

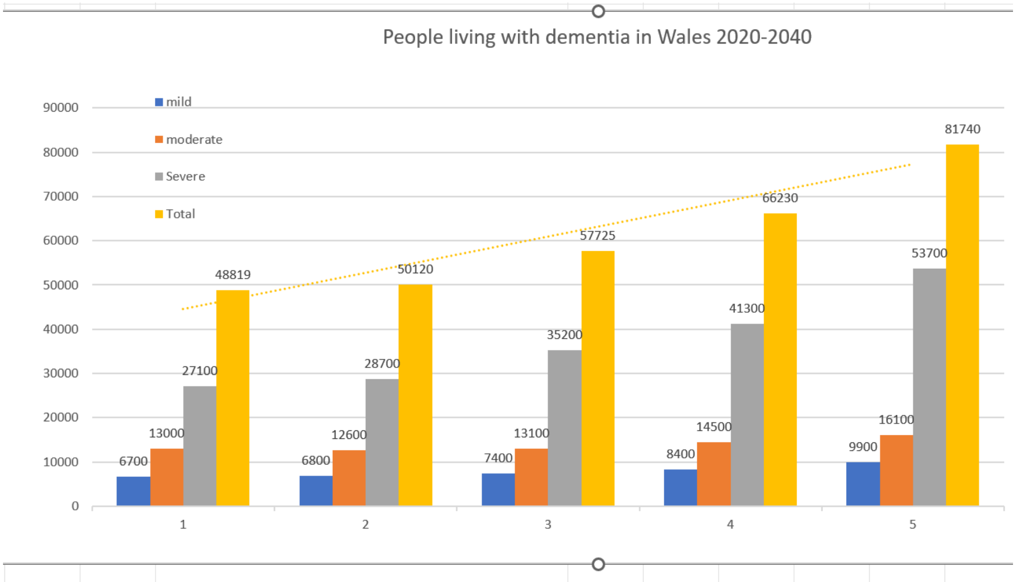
---

[10] Office of National Statistics, National Population Projections: 2022-based (January 2025).



However, this increase will also bring challenges, with a higher likelihood of individuals requiring health and social care services. Clinical advancements have improved survival but has led to a more complex range of needs and comorbidities within the population, and this is expected to grow. This shift will lead to a rise in the overall amount of ill-health, with more cases of chronic conditions, multi-morbidities, and cognitive impairments – increased risk factors which impact an individual's ability to return home. As a result, the increasing prevalence of long-term frailty is anticipated to significantly elevate the demand for social care services.

Associated with the aging population we see an increase in the number of people who have a form of dementia.



Alzheimer's Society UK (2019)

This cognitive impairment can at later stages lead to many complexities in terms of care and support which will impact on hospital discharge arrangements for some people. This is particulary significant for people who are no longer able to direct their own needs, make decisions about their care or have the ability to return home. The pathways of care monitoring data shows an increasing number of people who need mental capacity assessments, best interest decisions and involvement of the Court of Protection to arrange their ongoing care.

Despite the demographic challenges we can show a year-on-year improvement in terms of hospital flow against a backdrop of increasing demand, a huge reduction in hospital beds and concerns with inpatient care. Poor discharges and readmissions are increasingly commonplace as an under-pressure system attempts to balance risk of early discharge with attendances at emergency departments.

This is one case example of poor discharge planning captured by a local authority in Wales, where a frail elderly woman was discharged late from hospital on Christmas Eve 2024:

"*No-one knew she was being discharged, she was doubly incontinent and wasn't even wearing her own clothes when her son found her at home, by chance. She ended up going straight back to the hospital that evening! It was escalated to local NHS, yet no response or action was taken to investigate what happened.*"

Increasing complexity of care needs

With the changes in demographics and advancement in health care people are living longer with more complex medical conditions. Increased physical frailty and age-related cognitive decline such as dementia combine for many people. This can present a challenge for the individual, their family & unpaid carers and for assessment and care planning. The social work assessment has to gather information about both physical, cognitive and psychological impact of the persons presentation, their views wishes and feelings. Care planning is increasingly complex with the interface between health and social care needs needing a combined, integrated approach.

We have observed in Care Action Committee and pathways of care data that more people require joint health and social care assessments to support them to be discharged from hospital. We are also seeing a steady increase in the number of people who require Mental Capacity Act assessments, Best Interests decisions and the involvement of the Court or Protection to agree their care arrangements for discharge. These are intensive processes with a clear legal framework and by very nature take considerable time. Anyone with such needs is inevitably going to be in hospital more than 48hrs after being deemed 'clinically optimised'.

In April 2023, there were 32 delays associated with mental capacity & court of protection. In January 2025, this figure had more than doubled and has risen to 73.

Pathway of Care Delays by reason for delay and date

The significant reduction in hospital beds (including mental health and dementia) over last the 15 years

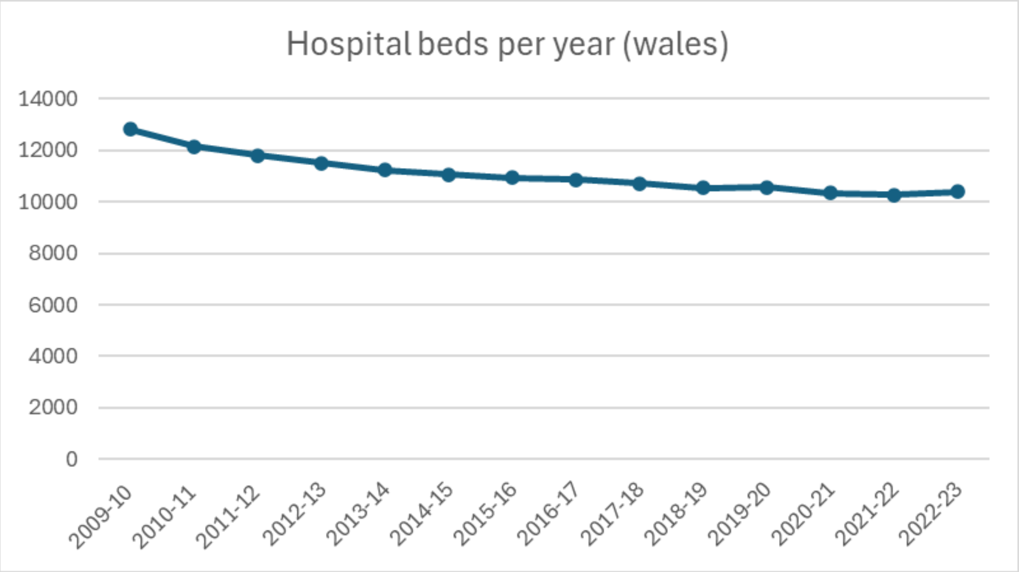
Despite increasing demographic demand and complexity we have seen a significant reduction in the number of hospital beds (including mental health and dementia) in Wales, with approximately 19% lost.

Year	Number of Hospital Beds[11]
2009-10	12,807
2010-11	12,149 ↓5.1%
2011-12	11,810 ↓2.8%

---

[11] StatsWales, NHS beds summary by year, 1989-90 onwards (August 2024).

2012-13	11,497 ↓2.7%
2013-14	11,241 ↓2.2%
2014-15	11,062 ↓1.6%
2015-16	10,935 ↓1.2%
2016-17	10,857 ↓0.7%
2017-18	10,712 ↓1.3%
2018-19	10,549 ↓1.5%
2019-20	10,564 ↓0.1%
2020-21	10,340 ↓2.1%
2021-22	10,276 ↓0.6%
2022-23	10,400 ↑1.2%
2023-24	10,446 ↑0.4%



Actual performance in relation to pathway of care

We often hear that the problems being faced by our acute hospital system directly correlate to social care delays, whilst this will have some impact, the preoccupation in this area may be disproportionate as the data below shows these "delays" in context of all available beds. At the end of January 2025, the total number of people recorded as their pathway being "delayed" (1,502 for all reasons) remains well below the reduction in the number of beds since 2009 (2,361 beds).

	Jan-25		
All Wales Data	**Jan-25**	**as % of all delays**	**as % of all beds**
Total Delays (All reasons)	**1502**		
Awaiting completion of assessment by social care	229	15.3	2.19
Awaiting completion of assessment by health	223	14.9	2.13
Awaiting start of new home care package	116	7.7	1.11
Awaiting social worker allocation	113	7.5	1.08
Awaiting joint assessment	150	10.0	1.44
Awaiting placement arrangements	38	2.5	0.36
Awaiting Residential Home availability	57	3.8	0.55
Awaiting Nursing Home Availability	57	3.8	0.55
Awaiting reablement care package	65	4.3	0.62
Awaiting funding decision FNC/CHC	24	1.6	0.23
Increasing complexity	**Jan-25**		
Mental Capacity / Court of Protection delays	65	4.3	0.62
Patient, family choice & refusal to move/be discharged	50	3.3	0.48

Avoidable harm and deconditioning in hospitals

Therapy staff in our hospitals are frequently required to assist with discharge planning due to a decrease in inpatient recovery and rehabilitation services, under the assumption that such care will be provided within the community once the patient has returned home. This shift of emphasis may indeed be better for the person but also represents a shift in responsibility from the NHS to social services & reablement teams, as previously referenced above.

In this regard, it should be noted that investment in community health services has not kept pace with demand or with the closure of beds.

The NHS Wales Executive 6 Goals for Urgent and Emergency National Programme, has one goal (Goal 5: Optimal hospital care and discharge practice from the point of admission) that is centred on inpatient care, to "*prevent deconditioning*". This programme seeks to redress an issue where suboptimal inpatient care and a lack of rehabilitation / therapy intervention, is leading to people coming to harm in our hospitals. It is important to highlight that inpatient therapy services are extremely limited or not available on weekends or bank holidays, which leads to increased levels of deconditioning and places additional strain on community services.

It is concerning to note that *"10 days in hospital (acute or community) leads to the equivalent of 10 years ageing in the muscles of people over 80 years old."*[12] This highlights the importance of delivering optimal outcomes and experiences for individuals in hospital settings.

This avoidable harm and loss of independence means older / frail people are more likely to require some form of care and support to return home, increasing the pressures on social care and already stretched community services. Rather than address the root cause of deconditioning i.e. suboptimal care, we see this being used as a rationale to move people out of hospital earlier.

We fear suboptimal hospital care is not only being unreported but has also become accepted. This rhetoric must be challenged, as routinely failing patients in our hospitals is unacceptable.

It is important to note that if a registered care provider, such as a residential care home, were found to be routinely "deconditioning an individual," it would be considered neglect. Such cases would be referred to the regulator, Care Inspectorate Wales, and assessed under safeguarding procedures. Without improvement, the care provider could face deregistration.

Social care has a responsibility to meet care and support needs as outlined in the Social Services and Wellbeing (Wales) Act 2014 national eligibility criteria. It should be noted this eligibility does not cover short-term illness or recovery from illness, which are features of the NHS Wales Act 2006. Although it does provide for the provision of reablement services, which the Act states should be jointly delivered with the NHS. This provision does not stipulate the type and nature of such services or the contributions from each partner, as a result, investment varies greatly across Wales, with the NHS contributing much less in some areas than others.

---

[12] NHS Wales Executive, Delivering optimal outcomes and experience for people in hospital, 2022.

The unfunded costs to local authorities in supporting early discharge / avoiding admissions

We have seen a number of initiatives to reduce the time spent in hospital, whether this was 1,000 beds[13] or the current 50-day challenge[14] and the ask is a similar one; for local authorities to support people to move out of hospital as quickly as possible and to provide this care in the community. This shift of care and responsibility, whilst attracting some short-term grant funding, comes at a significant cost to local authorities, affecting their ability to deliver wider community-based support.

While councils have made progress in reducing delays and expanding domiciliary and reablement services this has often come at the expense of other key areas of social care. With resources and staffing redirected to prioritising hospital discharges, services such as preventative care, early intervention, and long-term support for vulnerable individuals have faced increasing strain.

For example, to support a reduction in the length of a hospital stay by just 2 days for just one person (every day) who requires home care each day will cost the local authority circa £1,100 per week. Similarly, moving just one person a day to a care home to reduce the length of stay by 5 days, would cost £6,000 per week.

Similar work to provide care to prevent hospital admission also results in costs to local authorities. Preventing a 10-day admission (average for all ambulatory sensitive conditions) by providing domiciliary care for one person a day would cost approx. £5,100 or would cost £12,000 if one person a day was supported in residential care, instead of hospital for the same 10 days.

If we combine the relatively modest numbers above, the additional cost to this local authority in these scenarios is £1.23M per annum. If this was not provided, the cost to the NHS for this care in a hospital at £450 per person per day would be circa £4.4M per annum.

Whilst social care is more cost effective in this scenario, the hospital pressures mean that the £4.4M is not a cashable saving and the corresponding £1.23M investment in social care has not been forthcoming.

If we scale this further for all Wales i.e. all 22 local authorities, for just this minimal intervention we would see a cost of approximately £28M to local authorities and a corresponding cost avoidance to the NHS of £97M.

This demonstrates that a balanced approach is important; while hospital discharge is necessary, social care must also have the capacity to provide preventative and ongoing support. Without this balance, pressures on hospitals may reduce in the short term, but the demand for crisis interventions could increase, potentially making the system less sustainable over time.

---

[13] A Care Action Committee (CAC) was established in 2022 and chaired by the then Minister for Health and Social Care. It included key members from local government, health, and social care sectors. The CAC aimed to provide an additional 1,000 beds or equivalent community services during the 2022/23 winter period to ease system pressure and reduce delayed discharges. Although the target was not fully achieved, over 670 beds or equivalents were provided, significantly improving flow across the health and social care system.

[14] Welsh Government, [New 50-day challenge to improve hospital discharge and community care](),

Unacceptable gatekeeping of NHS Continuing Healthcare (CHC)

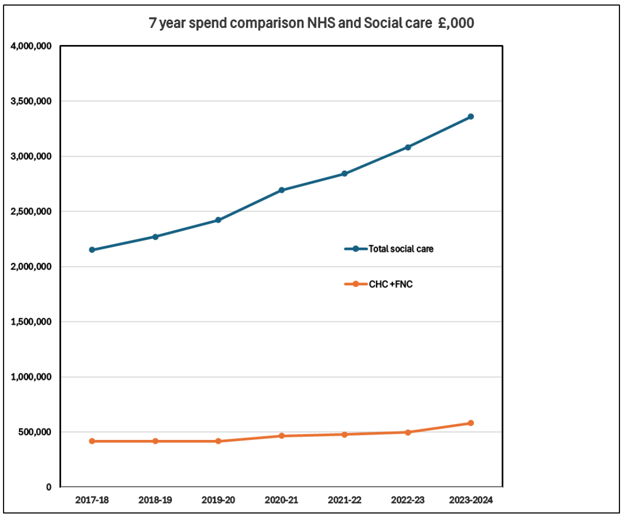
Despite demographic increases and increasing complexity, NHS Continuing Healthcare (CHC) budgets are not increasing to match this demand and in real terms are often reducing. Eligible citizens have a legal right to their entitlement for NHS care. Further, it can increase clinical risks as the wrong professionals are overseeing what should be clinically led care. We previously highlighted this in both the Senedd's Health and Social Care Committee's inquiry into supporting people with chronic conditions[15] and, most recently, in its scrutiny of the Health and Social Care (Wales) Bill.[16]

Delays in NHS agreement of funding of care arrangements for discharge from hospital in January 2025 was 24, (Stats Wales) this delay often relates to a panel decision regarding authorisation. It should be noted that all local authorities in Wales have confirmed that none of them use a panel for hospital discharge and have a clear scheme of delegation to enable rapid decision making.

By failing to apply CHC as outlined in the national policy, the NHS are, by default, utilising social care resources and staff that should be deployed to fill social care activities and are continually increasing local authority costs. Care workers being paid at, or around real living wage levels, are undertaking more and more complex, health-related activities. Yet, their status and renumeration is significantly below that of NHS directly employed staff and reduces the market capacity for social care. If the NHS were to directly deliver CHC care, we would see significant capacity released to the social care sector which would in turn increase responsiveness of the sector.

The inability to transfer care coordination has clinical risks and increases the risk of harm. Across Wales we see what might considered unlawful practice by the NHS in order to protect their budget and resources, with social care stepping in or continuing to provide care to people with clear health needs. There are many instances where local authorities are considering court intervention, including judicial review, in order to remedy this matter. Local authorities are routinely being forced to work outside their legal remit in order to ensure families have support.

Furthermore, the differential growth in spend between social care and NHS on funded nursing care and continuing care is shown in the graph below. This does not seem to correlate with the narrative of shift of investment from closure of hospital beds to a position of supporting people in their communities.



---

[15] ADSS Cymru, *[Senedd Cymru Health and Social Care Committee: Supporting people with chronic conditions](#)*, (2023).

[16] ADSS Cymru, *[Senedd Cymru Health and Social Care Committee: Health and Social Care (Wales) Bill](#)*, (June, 2024).

Moreover, analysis we have undertaken reveals stark inconsistencies in CHC and FNC funding across different health boards, leading to disparities in care access and creating inequities in service provision. It is also the case that CHC eligibility criteria seemed to vary across Wales, affecting equitable access to funding. Individuals in some health board regions were twice as likely to receive CHC funding compared to others, highlighting an inequitable system. Some local authorities were experiencing significant delays in CHC decisions, prolonging hospital stays unnecessarily. All of this places additional strain on local authority budgets because councils end up providing the care whilst negotiations on who pays for the care drag on for months, sometimes years.

Delays were noted by the NHS Executive in relation to hospital discharge for people with healthcare needs, and in Care Action Committee. Rather than address the root cause of these delays, such as bureaucratic processes around CHC and monitoring NHS performance the 50-day challenge suggested a policy of "no CHC consideration for hospital discharge". As outlined above, section 47 of the Social Services and Wellbeing (Wales) Act would prohibit social services from providing this care, yet some NHS bodies have interpreted the 50-day challenge to suggest that social care will provide such support pending consideration.

The CHC framework has an 8-week timescale for routine consideration and a fast process for people with more critical needs including end of life care. These timescales are systematically not adhered to and are not nationally monitored yet we monitor every stage of social care process for discharge. This is clearly an inequity that needs to change.

Why recording a 'delay' after just 48hrs is unreasonable

The new monitoring of pathways of care has a trigger point of a patient becoming "clinically optimised". As previously stated this does not necessarily mean the person is well or recovered. This clinically optimised determination starts the virtual clock and anyone still in hospital 48hrs later is considered a "delay". For many people with less complex needs, discharge will be via agreed pathways such as reablement.

For people with more complex needs they may require a range of services to support them to be discharged from hospital as they continue to recover. In order to determine the correct services a level of assessment is needed with the person, their family and the MDT. A care & support plan must be mutually agreed and the relevant care commissioned and arranged.

Meeting a new person such as social worker, trying to agree a plan for your care needs, discussing things with your family at visiting time, having views from the MDT on your care is a complex and difficult time for people, and can be overwhelming. Doing this whilst you are still unwell / not recovered from an acute illness is considerably more difficult.

Imagine a travel agent calling you whilst you had a cold / flu and asking you to try to plan a family holiday, it is very unlikely you would make a decision immediately, and would want time to consider your options, consult with your family, check your finances etc. Yet we expect people to work through an assessment, agree a care plan sometimes including moving to a care home which may cost the person up to £2,000 a week and for this to all be in place within 48hrs, or we will record this as a "delay" and will consider "reluctant discharge" policies being used.

Care must be taken to remember the individual at the centre of pathways of care discussions and their individual circumstances when planning discharge and ensuring this is done in a safe and timely manner. We acknowledge there must be a determining point in the persons journey home for monitoring purposes, but considering transfer home for a person with complex needs as being “delayed” if this takes more than 48hrs from them becoming ‘clinically optimised’ is clearly not a person-centred approach. (Please see Appendix 1 - care home process).

Conclusion

In conclusion, addressing the current challenges in our hospital settings requires a whole system approach that emphasises a collaboration between the NHS, local authorities, and community partners, rather than looking at one piece of the puzzle in isolation.

By focusing on person-centred care and fully integrated support systems, we can ensure that individuals receive the right care at the right time in the right setting. It is essential to invest in local authorities, community-based services and timely interventions that reduce unnecessary hospital admissions and facilitate sustainable care pathways. By re-evaluating the framework of this inquiry, we can move towards a genuinely integrated approach that serves the best interests of individuals, families, and communities across Wales.

Appendix 1: High level steps require to support a person to move to a care home

Referral – any source

Screening / Triage / Information, Assistance, Advice

How complex is this situation. Trusted assessor. Can care needs be met in the community. Likely to be self funding, person's known wishes and feelings, view of unpaid carers, indication of mental capacity needing to be considered, is the person well enough to start the assessment process etc

Allocation to a social worker as situation is complex

Initial considerations, capacity and consent to assessment / able to make decisions, background history, likelihood of needing MDT assessments to inform the Integrated Assessment e.g. Doctor, Occupational Therapist, nursing needs assessment etc. Persons wishes and feelings, family wishes and feelings.

Can the person go **home**? If not why not?

Integrated assessment under the Social Services and Wellbeing (Wales) Act 2014

For people with complex needs this is a skilled social work process, not just filling in a form, it must focus on the person's wishes and feelings ("what matters"), consider family wishes and feelings. Assess eligibility and look at persons personal outcomes care and support needs, this should include any Multidisciplinary team (MDT) assessments and recommendations, may need to include consideration of Mental Capacity Act, deprivations of liberty and MDT "best interest" decisions.

Can person be supported at **home**? If not why not?

Residential care is different from Nursing Care (latter must have nursing assessment completed and under the framework CHC must be considered prior to agreeing funded nursing care)

Care plan agreed with person / family outlining personal outcomes to be met.

Choice Family / person supported to choose a care home

Financial Assessment explained and completed. Self-funding? top up fee? affordability? Consideration for future sale of property / assets, impact on other family members at property etc. Inheritance. Deferred payment agreements/ legal charges etc. Some care home fees are approaching £2,000 per week, if you were spending £100K per year of your own money what level of choice and control would you expect to have about where you live and who with?

Preferred care provider is given the assessments & care plan to consider if they can meet the person's needs (RISCA requirement).

We may need the **Court of Protection** to authorise the move to the care home for some people.

Transport arranged to the care home for the person and some of their personal effects.

Personal belongings, for many people the space for personal items will be much reduced from a lifetime of living at home and can create a sense of loss – Which items would you take / leave if you were moving home? You would probably have a moving lorry. Now think that someone tells you that you can only have what will fit into a family car how would you feel?

A different life Person moves to a care home, they and their family adjust to a very different life.

For a person in hospital, ALL THIS should happen within 48 HRs of being clinically optimised otherwise we record it as a delay!

Annex 2 – Why do we need qualified social workers in hospital settings?

A personal insight from Alison Johnson – Social Worker and Team Manager for RCT Hospital Discharge Service.

With the growing introduction of Trusted Assessors in hospitals, it is certainly prudent to ask this question. All health and social care services currently exist in a context of a continued drive for efficiencies and savings - in not just time, but also in resources to meet ever growing demand. Providing advice, information and support as well as assessments of need by a generalist practitioner certainly has its place within the system of hospital discharge and can add immense value to the preventative agenda by linking people in with services and support at an earlier stage in their care journey. Additionally, freeing up more specialist practitioners from non-complex work provides a much-needed ease to demand volume on social work teams.

However, it is also vital to recognise the circumstances in which only input from a qualified practitioner will meet the needs and objectives of the individual, whether that be social work, occupational therapy or any of the allied professionals that form part of the multi-disciplinary arena. I will attempt to provide evidence of the social worker key skill set and its importance below. In essence, social workers provide:

- Specialist training in legal frameworks, laws, policies and statutory guidance to inform practice decisions, but also to ensure that individuals and carers benefit fully from their legal rights and protections. This is especially crucial in the context of the Mental Capacity Act (2005) and Best Interest Processes where sound, ethical and legally based judgements are required to be made and can also be subject to legal challenge - where ‘we just needed to get them out of hospital as quickly as we could’ does not hold much sway.
- Specialist skills in identifying safeguarding issues in the context of crisis intervention where things may not always be clearly defined, along with the interpersonal skills to sensitively draw out the relevant information at a time where emotions often run high.
- Confidence to challenge – not only other professionals, but the individual and their families themselves, in order to move forward safely and cohesively. This can be seen most clearly during dialogue which involves consideration of positive risk taking, as this can often be contentious due to an unintended focus on protection/safety at all costs, which is enhanced by the artificial hospital environment. Often this leads to workers needing to use their conflict resolution skills and engage in a continued process of negotiation to achieve the best outcomes.
- The ability to see the whole picture and coordinate those findings into an assessment and plan that represents all the things that matter to the person’s wellbeing, not just their medical recovery and physical act of discharge from a hospital bed. This not only results in person centred planning, but when done well, decreases readmission rates by the identification of broader social barriers – such as poverty, isolation, housing issues, access to community – and producing sustainable plans to reduce these.
- The ability to manage complexity within a short timescale – hospital social workers have an incredible level of skill in creating rapport quickly with people, often having to undo trust barriers caused by previous negative experiences, and always at a time when people and their families are recovering from crisis – both physically and emotionally. Often people present as having one set of barriers, but during conversation with a social worker, a far different picture can emerge which needs consideration. Whilst social workers strive to avoid creating dependency, all social workers should be people who those in need can

depend upon, and this is never more needed than in the navigation of complex systems and decisions that can have long term and life changing impacts.

- Use of skills to devise and broker complex care plans and referrals to other specialist services. This also involves ensuing appropriate ‘passing of the baton’ to the onward support mechanisms and services – including making sure that the person and their family do not get lost in this transition. This also involves having in depth knowledge of financial implications and options for people so that they understand the charges they will incur.

In conclusion, I hope that the above illustrates the unique skill set of social workers in hospitals, which in my view blends psychology, law, ethics, conflict management, crisis intervention, relationships, understanding of complex systems and financial implications and at times ‘detective work’, into tangible and sustainable personal outcomes. As the issues facing our society become more complex, it seems only reasonable to match that complexity with workers who have the training, skills, experience and aptitude to meet those challenges head on, with the support of general practitioners to act as a filter to channel demand to the right person at the right time.

Annex 3 - ADSS Cymru Position Paper on NHS Continuing Healthcare (2022)

ADSS Cymru Position Statement on Continuing NHS Healthcare For Adults in Wales

ADSS Cymru
Yn arwain Gwasanaethau Cymdeithasol yng Nghymru
Leading Social Services in Wales

(May 2022)

The role of ADSS Cymru is to represent the collective, authoritative voice of senior leaders who support vulnerable adults and children, their families, and communities. We offer a professional view on a range of national and regional issues of social care policy, practice, and resourcing. It is the only national body that can articulate the view of professionals who lead-social care services in Wales.

As a member-led organisation, ADSS Cymru is committed to using the wealth of its members' experience and expertise. We work-in partnership with other agencies, to influence the important strategic decisions around the development of health, social care, and public service delivery, benefitting the people the sector supports and those who work to deliver services.

One of our key priorities is to work constructively with Colleagues across all Local Authorities and Health Boards to ensure that the Continuing NHS Healthcare for Adults Framework and Guidance and any related practice guidance (such as Mental Capacity and Best Interest decisions) are universally understood and applied.

Continuing NHS Healthcare (CHC) is a package of care and support, arranged and funded by the NHS, where it has been assessed that the person's primary need is a health need. This is determined by consideration of the nature, intensity, complexity and unpredictability of the need. The care and support to meet these needs is free at the point of delivery (NHS Funded).

Section 47 of the Social Services and Well-being (Wales) Act 2014 states that:
"A local authority may not meet a person's needs for care and support (including a carer's needs for support) under section 35 to 45 by providing for or arranging for the provision of a service or facility which is required to be provided under a health enactment, unless doing so would be incidental or ancillary to doing something else to meet needs under those sections."

Therefore, the Social Services and Well-being Act makes it unlawful for local authorities to provide services which are the responsibility of the NHS.

The last 20 years has seen perhaps more significant advancements in medical care & treatment than anytime in our history. People in Wales are living longer, many with a range of complex medical conditions, which represents a good news story for our citizens. In its initial conception and design, the social care system was not necessarily constructed to meet the needs of people with the increasing complexity of need associated with these advancements. Generationally, there has been a strong emphasis on community-based care and move out of long stay institutions and community hospitals. The expectations of the current generation is very different from previous, which is again welcomed and represents a positive advancement in Wales. Nationally, there has also been a strong drive to move sub-acute medicine and rehabilitation out of hospital sites into communities. There has also been an emphasis to reduce/rationalise the hospital bed base over this time, which needs to be carefully balanced with the increased demand for such services from an ageing population with complex needs. ADSS Cymru are supportive the concept that community services deliver better outcomes for people, however we advocate the need of investment in both NHS & social care community services to develop the capacity needed to accommodate this community approach.

In practice, this approach has contributed to a shift of responsibility from the NHS and inpatient services to social care and community services. District nursing teams have faced long standing pressures with high demands and it is common place for them to delegate activities to care staff that a decade or so ago would have been delivered directly by nurses. Similarly, nursing homes can struggle to attract and retain qualified nurses, leading care providers to accept people with increasingly complex needs with “residential” settings rather than “nursing care”. This system shift has occurred gradually overtime and is potentially on an unconscious level. Practitioners are now very familiar with complexity and can consider some things now, to be routine that would have previously considered as complex, this can lead to an unconscious bias for Multi-Disciplinary Team’s (MDTs). Moreover, when considering thresholds for continuing healthcare, the potential for scores to be lower than the empirical evidence would suggest that the MDT’s can also be led to consider tasks as “social care”. It is important to note that the threshold for CHC and the responsibilities of social care in law have not been changed, so we need to work with MDTs to guard against this unconscious drift.

A recent survey in relation to continuing healthcare sent to all Local Authorities in Wales, highlighted areas that are working well and areas that could be improved. The themes from this are included in Appendix 1. ADSS Cymru is keen to work with NHS colleagues to agree a national operating framework which enables us as a health and social care system to provide clarity about the application of the framework and guidance across Wales. This will include ensuring that related processes dovetail with the CHC process, with a particular focus on the following:

- Ensuring that residents make informed choices in relation to consent and understand the implications of declining to the CHC assessment process or subsequent care package.
- Ensuring a common understanding of thresholds for CHC and the limits of social care as defined in S.47 of the Social Services & Wellbeing (Wales) Act 2014.
- Working in partnership to ensure no-one “falls through the gaps”.
- Transition from Children and Young People’s Continuing Care to Continuing NHS Healthcare for Adults.
- A smooth transition between health and social care that offers the individual and their family as minimal disruption as possible.
- Ensuring equity of access across disciplines.
- Mental Capacity Act and Best Interest decisions.
- Fast-track CHC decisions.
- Interface with Direct Payments and continuity of care.
- Interface with Section 117 aftercare.
- Configuration and role of the Multi-Disciplinary Team.
- Configuration and role of the ratification panel.
- Dispute resolution.
- Best practice in relation to hospital transfer to facilitate right care, in the right place at the right time.

Any change in peoples’ health needs can present an extremely challenging time for them and their families. It is paramount that health and social care sectors collaborate to ensure we work in an open and transparent way, getting it right for people who use our services. It is also paramount that we have the right pathways and tools to support our practitioners to work confidently and constructively challenge themselves and other.

ENDS

Appendix 1 - Themes from Local Authority Survey in relation to NHS Continuing Health Care

A survey was circulated to all 22 Local Authorities in Wales to ask them about their experiences in relation to NHS continuing health care, there was a very high response rate and all regions were represented in the returns. Some LA's completed 2 returns due to the distinctly different process they experienced for people who have a learning disability.

What works well about CHC?

Generally, there are good working relationship with MDT members on a day-to-day basis, with good levels of trust at this level.

Discharge to recover and assess pathways work well in some areas.

Most Local Authorities have a lead officer for CHC, most social care staff are aware of triggers for CHC. One area has a shared database for CHC. Another has fortnightly meetings to discuss cases that appear to be CHC related. One area has developed a Standard Operating Procedure for "what makes a good MDT", another has an internal "NICU tool", to work through Nature, Intensity, Complexity and Unpredictability, which informs requests to the local health board for MDT consideration.

Some areas report good links with palliative care teams.

Joint care planning and funding agreements for people who are below the CHC threshold.
Good information sharing between commissioning and long-term care teams in relation to COVID outbreaks, intelligence about provider performance.

Unfortunately, 2 areas reported that it has being difficult to find anything that works well.

What does not work well?

Over time, the pressures within heath care and move to community services has seen an increase in delegation to social care provision from health staff. The complexity of cases held by social care has slowly but consistently increased over the last 20 years; perhaps unconsciously, staff thresholds for complexity have diminished with more & more healthcare tasks seen as routine and delivered under the umbrella of social care.
A lack of consistency has meant that people with different diagnosis are treated differently rather than following the agreed process, is a consistent theme across Wales. For example, there is often a different process and panel for consideration of learning disability, as it is felt less likely for this group to be able to access CHC, if they present with similar needs.

The experience of MDT working is highly dependent on local relationships rather than objective consideration based on the criteria.

MDT decisions are routinely not accepted by Health Board panels and can be overturned.
Social care is often seen as the default, generally there is a lack of understanding of the legal limits of social care, (S.47 Social Services and Wellbeing (Wales) Act 2014) and that needs above this should be met by health regardless of CHC outcomes.

Highlighting the need for CHC consideration seems to fall to social care staff rather than being promoted routinely by health staff. There is also poor communication with the individual requiring care and their families on CHC process and eligibility.

There is no evidence of consideration of the guidance or case law in terms of judgement on levels of care, with some areas appearing to have local thresholds and processes that are not in line with the legislation. Moreover, there is considerable pressure to “just go 50-50” without going through formal process.

The evidence indicated that the CHC fast-track process is not being applied consistently, it was reported that a common reason for rejection of the clinical opinion was that the person was “not end of life”, and that clinician opinions can be overturned by Health Board panels.

Timescales for consideration of CHC are often lengthy and fall outside the 8-week timescales. A person can be reimbursed for their contribution, but the Local Authority is not.

The disputes process is not adhered to consistently, in particular MDT / peer review.
There is a lack of understanding of Mental Capacity Act and best interest decision making in relation to CHC, in particular, in relation to direct payments. There have been reports of people being informed that they will lose their direct payment/ carers if they agree to CHC being considered.

Discharge to assess can be negative with people stranded in a care home with long waits for CHC consideration, which can be quicker in hospital as full MDT is “onsite”.

There are frequent instances of Health Board commissioners and senior managers attending MDT’s and “directing the outcome”, including considering the likely provision before the eligibility. There is no clear separation of MDT and commissioning process.

There is an overemphasis on the type of care provision and tasks to be completed, rather than on the persons needs and presenting nature, complexity, intensity & unpredictability.

There are examples of people with “managed needs” not being able to access CHC.
There is a lack of understanding of the interface between CHC and S.117 aftercare (within the Mental Health Act).
There are persistent challenges relating to transition from childcare. Where a person has clear health needs, CHC is often only considered post 18.

What needs to change?

MDTs to work to the framework and case law rather than local interpretation and not to allow decisions to drift either in time or threshold due to numbers of “people with complex needs” on caseloads.

Need to support MDT’s to consider CHC as a governance matter and way of ensuring the right level of support is provided rather than thinking of it as a funding stream.

Joint mandatory training that covers CHC, the Social Services and Wellbeing (Wales) Act 2014, including S.47 limitations, the Mental Capacity Act, case law and the interface with S.117 training for meeting chairs.
Trust in MDT decision making and less emphasis / reliance on quality assurance panels.

Fast track process to be followed and medical/nursing professional opinion to be fully accepted to ensure timely support during crisis / period of palliative care - removing the myth of a “person has more than 6 weeks so not eligible” rationale.

Clear separation of MDT decision making from commissioning and cost.

Need for consistency across professionals/ across health board regions / across customer groups and Directorates in particular Learning Disability & mental health, where people should have equal access to CHC. There also needs to be more consistency across Children's and Adult's provision.

Amend legislation to allow Direct Payments for CHC to ensure consistency of worker when the person moves through a Local Authority service to CHC; as the current process is distressing for families and workers.
Active promotion of the right to CHC consideration and support; improved communication with the person and their family and an automatic right to advocacy as part of the process.

Improve the timeliness of response – the Local Authority, as well as person, should be reimbursed if care has been funded and there is a delay.

A clearer disputes resolution process.

A national standard operating procedure or code of practice across all disciplines and diagnosis, to underpin the CHC guidance; in particular, a clear fast track process.
Greater use of regional pooled budgets.

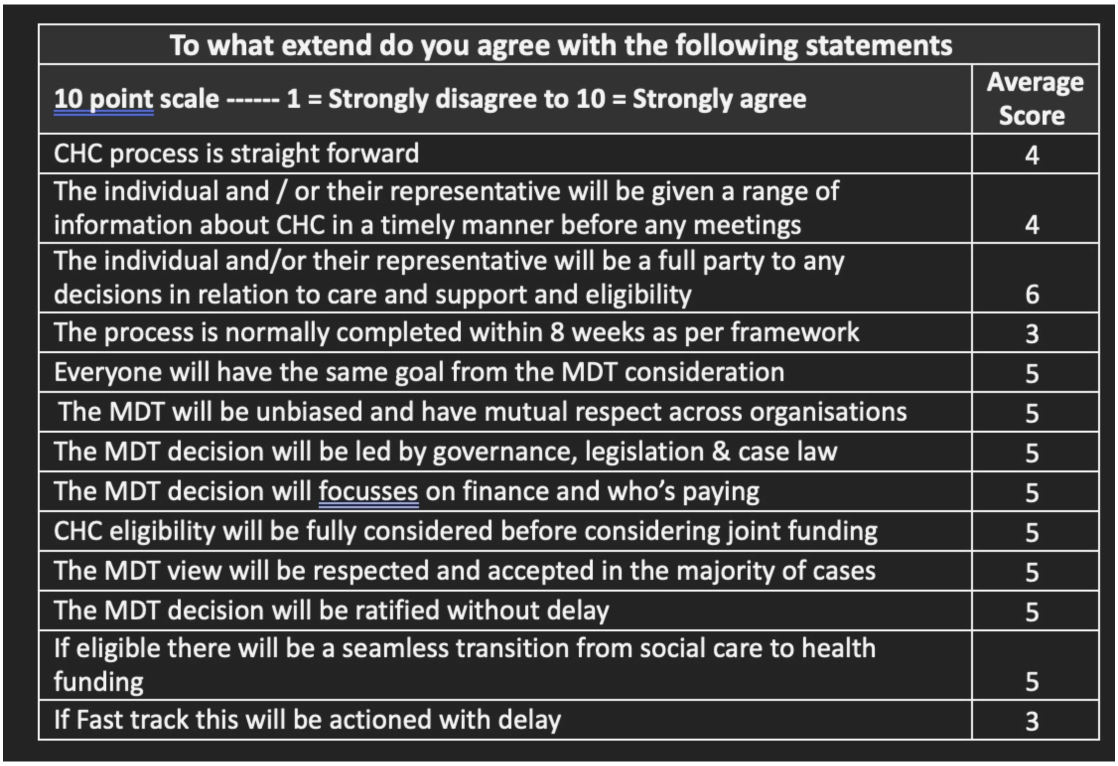
How accessible is CHC within your area

Q 1 Does your health board area promote CHC?

Responses indicate that there is limited evidence that CHC is promoted in Wales; all responses received replied, 'No'.

Q 2 Does your health board operate a single process for CHC or different ones depending on diagnosis / specialism e.g. Learning Disability & Mental Health?

All responses received indicate there is a separate process in operation depending on discipline / diagnosis, and that thresholds are different. This has potential implications under equality duties.



To what extend do you agree with the following statements	
10 point scale ------ 1 = Strongly disagree to 10 = Strongly agree	**Average Score**
CHC process is straight forward	4
The individual and / or their representative will be given a range of information about CHC in a timely manner before any meetings	4
The individual and/or their representative will be a full party to any decisions in relation to care and support and eligibility	6
The process is normally completed within 8 weeks as per framework	3
Everyone will have the same goal from the MDT consideration	5
The MDT will be unbiased and have mutual respect across organisations	5
The MDT decision will be led by governance, legislation & case law	5
The MDT decision will focusses on finance and who's paying	5
CHC eligibility will be fully considered before considering joint funding	5
The MDT view will be respected and accepted in the majority of cases	5
The MDT decision will be ratified without delay	5
If eligible there will be a seamless transition from social care to health funding	5
If Fast track this will be actioned with delay	3

Threshold for CHC in Wales

The last question of the survey asked if the Pamela Coughlin case for care funding was presented in your health board in your area, do you think she would be likely to get CHC funding?

All areas replying indicated that despite the case law stating that all people with needs similar to, or greater than, Pamela Coughlin, should be eligible for CHC, she would unlikely to be approved by the CHC panel as being eligible for CHC in any area in Wales.

Welsh NHS Confederation
Conffederasiwn GIG Cymru

	The Welsh NHS Confederation response to the Local Government and Housing Committee's inquiry on the role of local authorities in supporting hospital discharges
Contact	Haleema Khan, Policy and Public Affairs Officer, Welsh NHS Confederation Haleema.Khan@welshconfed.org
Date	28 February 2025

Introduction

1. The Welsh NHS Confederation welcomes the opportunity to respond to the Local Government and Housing Committee's inquiry on the role of local authorities in supporting hospital discharges.

2. The Welsh NHS Confederation represents the seven Local Health Boards, three NHS Trusts (Velindre University NHS Trust, Welsh Ambulance Services University NHS Trust, and Public Health Wales NHS Trust), and two Special Health Authorities (Digital Health and Care Wales and Health Education and Improvement Wales). The twelve organisations make up our membership. We also host NHS Wales Employers and are part of the NHS Confederation.

The importance of health and social care working in partnership

3. Across Wales, NHS and social care organisations are working in partnership. Social care services play a crucial role in care pathways – keeping people well for longer outside of hospital and enabling faster, safer discharges home. Every week a significant number of people are discharged out of hospital, for example in Aneurin Bevan University hospital the average number of people discharged per week is between 2,100 and 2,300, with just under half having had an overnight stay.

4. While social care services support thousands of people every day, social care services are facing significant challenges, including vulnerabilities in funding and market stability, increased demand, growing unmet need and high levels of staff vacancies. The impact is that people are missing out on vital care and support, leaving them less independent, more vulnerable and more likely to rely on healthcare services.

5. Social care plays a significant role in keeping people well for longer outside of hospital and the sector has more beds than the NHS. For every hospital bed (10,400), there are approximately ten social care beds. Specifically, there are 27,000 care home beds and around 75,000 individuals supported at home.

6. The NHS is reliant on a sustainable social care system, and issues of capacity and workforce in social care are having serious implications on the NHS' ability to discharge large numbers of patients from hospital. At the time of writing, there are over 1,500

adults occupying an NHS hospital bed who are ‘clinically optimised’ ready to return home or move on to the next stage of care, that experienced a delay in their transfer of more than 48 hours beyond the point they were clinically optimised. This equates to roughly 14% of all NHS hospital beds.

7. Delays in discharge can lead to inpatients being cared for in settings which are not the most appropriate for their need and could introduce additional risks of harm to them, including hospital-acquired infections. The increased length of stay in hospital can impact patients physical and mental health. Physically, patients may experience muscle wastage and a loss of mobility as a result of extended periods of unnecessary bed rest, with delays resulting in a requirement for an enhanced level of care at an earlier stage than would otherwise have been necessary. Members have also noted that patients often feel low when experiencing delays in hospital because they want to be able to leave hospital and go back to their place of residence.

8. Apart from the negative impact on the patients themselves and their outcomes, as evidenced in the Health and Social Care Committee inquiry in 2022, this also slows down the flow of patients through hospitals, affecting care available for others. It has a knock-on effect on other services, included the Welsh Ambulance Services ability to provide effective and rapid responses as well as hospital interventions, elective capacity and planned care procedures and services.

Committee’s Terms of Reference

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

9. Due to the significant financial challenges and demand for social care services, our members agree that there are issues regarding the effectiveness of local authorities (LAs) (primarily social services) in supporting safe, timely and efficient discharges from hospital.

10. Delayed hospital discharges in Wales, for patients deemed clinically optimised (CO), has a significant impact on the NHS. Evidence shows a large reduction in hospital inpatient capacity, at times reaching nearly a quarter of hospital bed capacity, due to patients who are not discharged in a timely manner following a CO decision. Elderly patients awaiting care home placements (due to assessment, availability, or choice) experience the longest delays. Staying in hospital for longer than necessary can also lead to additional harm for patients, making them less independent.

11. The relationships between social work and hospital teams within local health boards (LHBs) are vital and overall are positive and effective, with timely responses to inpatient referrals and robust systems in place. Co-location of teams, particularly those with joint health and LAs representation, demonstrates highly effective working relationships and systems. However, a disparity exists between in-hours and out-of-hours support from LAs, with out-of-hours support for hospital discharges being weaker. This may be due to

a perceived higher level of risk aversion to safe discharge at night compared to the daytime.

12. Our members stated that the effectiveness of LAs in supporting safe, timely, and efficient discharges from hospital in Wales can currently be evidenced through a combination of qualitative and quantitative measures which if used together could paint an accurate reflection of the state of play. However, current national practice and scrutiny do not appropriately bring the measures together and their scrutiny on an individual basis form a fragmented view. The measures could help assess how well discharge processes are managed and whether they lead to positive outcomes for patients, carers, and the wider healthcare and social care system.

13. Several key measures can be implemented to evidence effectiveness of hospital discharge in Wales. These include a greater focus on admission avoidance through initiatives like "Frailty by the front door" and increased home-based care. Monitoring the Average Length of Stay (LOS) post-discharge assessment, specifically how long patients wait in hospital for social care assessments and packages, helps highlight the efficiency of discharge processes. A reduction in LOS compared to benchmarks suggests timely social service support.

14. Furthermore, Tracking Discharge to Recover & Assess (D2RA) models, where patients are discharged to appropriate settings (home or intermediate care) while assessments continue, demonstrates effective discharge management. Also, monitoring the number of delayed discharges specifically due to social care factors via monthly Welsh Government reports provides direct evidence of discharge timeliness and effectiveness.

15. Additionally, the average time it takes from a decision to discharge a patient to the arrangement of a home care package is a clear indicator of social services' responsiveness. Shorter times suggest better coordination between partners and efficiency of practice between health / social care and providers. Moreover, the data on the availability of suitable care home placements can be used to assess how well LAs are meeting the demand for residential care.

16. Finally, several other metrics can be used to evaluate and improve hospital discharge effectiveness in Wales. These include readmission rates within a specific timeframe (e.g., 28 days) which can indicate the quality of discharge planning and post-discharge care. Higher rates suggest potential inadequacies. Patient satisfaction surveys offer valuable qualitative feedback on the discharge experience, including communication, quality of care, and support. Sharing best practices from adverse discharges and existing survey initiatives can promote a consistent approach. Monitoring safety incidents post-discharge, such as falls or medication errors, provides further insights into the safety and effectiveness of inter-agency discharge management.

17. Ultimately, it is important to note that though LAs are very responsive in times of high escalation and will work in a business continuity model to ensure all resources are supporting discharge planning, our members have suggested that continuous engagement between LAs and LHBs is important to prevent avoidable admissions and ensure true integration of health and wellbeing assessments.

- **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.**

18. Our members have stated that the scale of the current situation with delayed transfers of care from hospital needs improvement.

19. Our members acknowledge that the overall performance around delayed transfers of care has demonstrated improvement in line with the Care Action Committee targets during 2024/25. However, as previously highlighted in our evidence, there are still several delays and the number of hospital bed days lost is considerable.

- **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.**

20. Our members agree that the main barriers listed above impact LAs ability to effectively facilitating the discharge of patients with care and support needs. The barriers contribute to hospital discharge delays, which in turn lead to bed shortages, increased NHS costs, and poorer patient outcomes.

    - **Social care capacity and workforce shortages**

21. Our members have stated that there is a shortage of social care workers, including domiciliary care staff and care home workers, due to recruitment and retention issues that are well documented. The position is improving and significant efforts are being made by all partners to recruit new social care staff into the system, however the issue of low pay and poor working conditions for care workers is impacting social care capacity. Disparities in pay, terms and conditions compared to NHS counterparts, coupled with limited career progression and high workloads, contribute to high staff turnover and the increased demand for care services, including those with complex needs, is leading to burnout and increased absenteeism among care workers, further straining the already stretched workforce.

22. Additionally, a shortage of trained staff and appropriate facilities to support the growing number of individuals with complex needs (such as dementia, mental health issues, or learning disabilities) can significantly delay hospital discharges. While some areas, like Disability Services in North Wales, have leading strategies, there is a recognised need to acknowledge the cost of specialist provision and invest accordingly.

- **Waits for care assessments (and other assessment related issues)**

23. The high caseloads and limited resources within LAs social services can slow down the completion of necessary care assessments, a prerequisite for discharge. Additionally, lengthy bureaucratic processes for determining eligibility and funding for care packages, along with risk-averse nursing assessments that may require double staffing for Plans of Care (POCs), further exacerbate discharge delays.

24. Social worker assessment is the most frequently reported cause of Pathway of Care Delays (POCD). While there are ongoing efforts to speed up the process, it is hampered by the complex assessments needed for elderly, frail, and vulnerable patients. These assessments are lengthy due to the complexity of individual patient situations, often involving Mental Capacity Act (MCA) assessments, which require careful scheduling to accommodate the patient and their families, organising best interest meetings, and ensuring the right people are present.

25. Communication challenges and delays in early assessments also hinder efficient hospital discharges in Wales. Effective coordination between hospital discharge teams, social workers, and community care providers is crucial, and breakdowns in communication can significantly slow the process. Furthermore, delays in initiating assessments before a patient is clinically optimised for discharge (a process that ideally should begin upon hospital admission) result in unnecessarily prolonged hospital stays.

- **Challenges in arranging care home placements or home care packages**

26. Due to the complexity of our elderly frail cohort of patients, it is becoming more and more difficult to find suitable placements that can meet people’s needs. To address this, a number of LHBs and LAs are working together on a joint assessment, which will provide care homes with a complete and accurate picture of the patient's needs.

27. Moreover, the limited availability of care homes and care home placements is another challenge effecting timely hospital discharge. Many care homes face funding challenges, leading to closures or reduced capacity. The risk is that they will develop their offer for self-funders and less complex residents as complex care is not always funded appropriately.

- **Disagreements or legislative barriers affecting discharge decisions**

28. Disagreements frequently arise between LAs and the LHBs regarding Continuing Healthcare (CHC) eligibility. Although CHC assessments are health-led, the LA sometimes disputes the Decision Support Tool (DST) outcome. In these cases, transferring the patient to a Regional Integration Fund (RIF)-funded Discharge to Assess bed (in a care home) for continued assessment outside the hospital is considered, but this is often difficult to arrange.

29. Additionally, a growing issue is the differing interpretations of legislation, particularly regarding the Court of Protection (COP), between the LAs and LHBs. LHBs often adopt a more pragmatic approach, either advocating for interim placements while COP procedures are underway or determining that COP involvement is not necessary due to low risk and the absence of potential challenges. Whereas there have been many conversations with LA colleagues regarding the view that COP is not needed which

sometimes leads to LA stating that if the LHBs pursues that route, the LA will then not discharge their duty to commission the placement required to enable the discharge. This leads to a stand-off where LHBs are left with no choice but to follow the lead of the LA and wait for the outcome of the COP.

30. Legal and ethical considerations arise when patients or their families contest discharge decisions, often due to concerns about care arrangements or a preference for remaining in the hospital. Capacity and best interest decision-making for patients lacking mental capacity adds further complexity, requiring additional assessments and legal oversight.

- **Other**

31. Our members have highlighted that the range of legislation, policy and strategies relating to the integration of health and social care, and specifically hospital discharge, can cause confusion in the system. There are multiple programmes, initiatives and short-term funding provided to support hospital discharge, and by strengthening accountability and simplifying the landscape it could provide increased clarity and direction.

32. Housing-related issues are a growing obstacle to timely patient discharge and transfers of care, primarily due to LA' difficulties in securing appropriate care and accommodation. Long delays arise from housing adaptations due to a lack of clear completion timelines and a complex priority allocation system, often forcing patients into suboptimal living situations while they wait. Limited housing stock, coupled with a lack of prioritisation for those awaiting hospital discharge, creates blockages and impacts step-down facilities, further disrupting the care pathway.

33. Furthermore, sourcing bespoke placements is even more challenging, and any delay in the pathway has a ripple effect on healthcare provision. Also, disputes over property cleaning and the subsequent refusal of social care agencies to provide domiciliary care until properties are cleaned to a suitable standard create additional delays, highlighting the complexities and challenges within the system.

34. Lastly, geographical disparities, especially in rural areas, create additional difficulties due to long travel distances for care workers and fewer available providers.

- **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.**

35. Our members agree that there are variations in hospital discharge practices throughout Wales and this does have an impact on LA delivery.

36. Across Wales, hospital discharge practices vary significantly. Key variations include:

- Workforce and resource disparities: Some LAs struggle with social worker shortages more than others, limiting their ability to assess patients quickly. Also, availability of domiciliary care and care home placements varies, leading to differing delays in discharge.

- Funding and commissioning differences: Variability in how NHS Continuing Healthcare (CHC) funding is applied can lead to disputes over who funds post-discharge care. LAs may also have different levels of investment in reablement services, affecting their ability to support people at home post-discharge.
- Use of technology and digital systems: Some areas in Wales use real-time digital systems to track patient status and care availability, while others rely on paper-based or disconnected systems, causing delays in information sharing.

37. To improve matters, there is a need to create a more standardised, efficient, and equitable approach to hospital discharge. Our members proposed several strategies could be adopted for regional implementation:

- Embed the Nationally Standardised Hospital Discharge Guidance (2023): Further embedding of the Wales-wide hospital discharge guidance which sets out clear expectations for LAs and LHBs to follow. Also, establishing nationally agreed timeframes for social care assessments and care package arrangements for those within the confines of hospitals.
- Enhance collaboration between LHBs and LA: Improving collaboration between LHBs and LAs is crucial for streamlining hospital discharges in Wales. This can be achieved by embedding joint hospital discharge teams, comprised of social workers and NHS staff, in all major hospitals. Ensuring Multi-Disciplinary Team (MDT) meetings consistently include LA representatives in all necessary discharge planning is also essential. Finally, enhancing communication channels between LHBs and social care teams, enabling timely information sharing, will further facilitate smoother transitions.
- Address workforce challenges with a national recruitment and retention strategy: Supporting strong leadership and workforce planning capacity for the recruitment of social workers and domiciliary care staff to enable timely assessments and care delivery. This includes ensuring the single standardised national approach to the training and accreditation of social workers is further embedded through Social Care Wales with a clear career pathway identified. Also, offering standardised training and professional development to improve discharge-related skills across all LA areas.
- Improve data sharing protocols akin to Covid times and digital providers to access real-time patient information: Introduce automated alerts to notify social services of pending discharges as early as possible. Also, establish and standardise the use of electronic care records across LHBs settings and social care to improve continuity of care.
- Encourage innovative and flexible care models – with a focus on prevention: Expand hospital-at-home services to manage more patients outside hospital settings prior to or to avoid acute admission. Also, developing rapid response home care teams capable of providing short-term support before hospital admission and immediately after discharge can prevent unnecessary admissions and facilitate timely releases. Additionally, establishing integrated prevention of admission teams can proactively address issues and further reduce hospital admissions.
- Strengthen accountability and performance monitoring: Establish national whole system outcome-based suite of indicators for discharge timeliness, social care assessments, and patient outcomes. Annual reporting on discharge performance, collaboratively produced by each LA and health board, should be required. These reports should highlight best practices while taking a holistic view, incorporating both quantitative and qualitative data. Finally, implementing peer reviews and shared learning forums will enable LA to learn from high-performing areas within their regions and beyond.

38. To reduce discharge delays and promote a more equitable approach, our members have suggested that LAs and LHB partners should focus on:

- Investing in a range of system-wide community roles, including occupational therapists, physiotherapists, pharmacists, and increased social care workforce capacity.
- Standardising hospital discharge processes across all health boards areas to ensure consistency.
- Leveraging digital tools to improve communication and efficiency within the discharge process.

39. Overall, by scaling up best practices and fostering a greater pan-national collaboration, our members proposed that as a country Wales can create a more seamless, timely, and person-centred hospital discharge system, ultimately improving the outcomes for patients and reducing pressure on both hospitals and LA services.

- **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.**

40. Our members agree that improvements need to be made to the assessment of current discharge processes and procedures at a local government and national level.

41. Our members acknowledge that support offered through the NHS Executive team and the six goals programme, has enabled representatives from all LHBs and LAs to meet frequently at a national level. This has enabled sharing experiences, best practice, resolving issues with delay codes, identifying common causes of delay, and highlighting these to seek national support in resolution. Areas of increasingly common concern amongst members are housing issues, mental capacity, and court of protection.

42. However, while sharing systems and processes for reviewing long delays has been beneficial in identifying areas for improvement, and tools like the Discharge Toolkit and revised patient information leaflets have been developed to support smoother discharges, these efforts are hampered by funding challenges. Specifically, additional funding allocated late in the financial year has had minimal impact on the core reasons for discharge planning delays. The time-limited nature of this funding also makes it difficult to recruit and retain the necessary skilled staff to address these systemic issues.

43. Our members have emphasised that it is important to get the balance between support provided by the national teams and monitoring right. The reporting required is substantial.

44. Finally, as highlighted within the Welsh Government's long-term plan, A Healthier Wales, the ambition is to bring health and social care together so that services are designed and delivered around the needs and preferences of individuals and there is seamless whole system approach to health and social care. Our members have suggested one way to

support this would be to have inter-professional and interagency standards across health and social care to provide standardisation.

Further information

45. Our members agree that LAs social services' support for timely hospital discharges needs to improve to ensure that LAs are complying with their statutory duties. Delayed discharges potentially harming patients, especially the elderly awaiting care home placements. These delays are caused by a complex interplay of factors, including workforce issues (low pay, burnout, staff shortages), difficulties in arranging appropriate care (care home availability, home care capacity), systemic inefficiencies (delayed assessments, bureaucratic processes, communication breakdowns), and disagreements over funding and legal considerations.

46. To address these issues, strategies can be implemented to improve collaboration between LHBs and LAs such as the enhancement of community support services, standardised performance indicators and reporting, and investment in the social care workforce. The goal is to create a more efficient and equitable discharge process, ultimately improving patient outcomes and reducing strain on the NHS.

47. Furthermore, though our members acknowledge the Committee’s focus on discharge, it is vital the Committee also considers the wider Social Services and Well-being Act 2014. The shift to the prevention and early intervention agenda is an essential focus to minimise the escalation of critical need and avoiding future hospital admissions by increasing the care and support provided to people in their communities to achieve their own well-being and in line with ‘what matters to them’.

48. Moreover, the capacity to support community care and discharge medically fit patients is a major challenge due to immense system pressures. However, the fragility of the social care sector, with some councils and providers facing potential bankruptcy, poses a significant threat. Social care is crucial for independence, preventing admissions, and facilitating timely discharges, which in turn enables the NHS to function effectively.

49. The sustainability of the social care sector and working in partnership with social care organisations is a priority for the Welsh NHS Confederation. At a national level we work closely with a range of organisations including ADSS Cymru, WLGA, Social Care Wales and Care Forum Wales and have made consistent calls for the UK and Welsh Governments to support integration between health and care services and create a sustainable financial model for the sector.

Y Pwyllgor Cyfrifon Cyhoeddus a Gweinyddiaeth Gyhoeddus
—
Public Accounts and Public Administration Committee

Senedd Cymru
Bae Caerdydd, Caerdydd, CF99 1SN
SeneddCCGG@Senedd.cymru
senedd.cymru/SeneddCCGG
0300 200 6565
—
Welsh Parliament
Cardiff Bay, Cardiff, CF99 1SN
SeneddPAPA@senedd.wales
senedd.wales/SeneddPAPA
0300 200 6565

John Griffiths MS
Chair
Local Government and Housing Committee

18 March 2025

Dear John,

Audit Wales' report: Financial sustainability of local government

During our meeting on Wednesday 13 March, we considered the above report and believe that its content falls within your Committee's remit. As such, you may wish to include this report in any future discussions on your forward work programme.

We would therefore be grateful if you could confirm your proposed course of action regarding this accordingly.

Yours sincerely,

Mark Isherwood MS

Chair, Public Accounts and Public Administration Committee

Croesewir gohebiaeth yn Gymraeg neu Saesneg.
We welcome correspondence in Welsh or English.