HD 03
Rôl awdurdodau lleol o ran cefnogi'r broses o ryddhau cleifion o'r Ysbyty
The role of local authorities in supporting hospital discharges
Ymateb gan: Age Connects Morgannwg
Response from: Age Connects Morgannwg

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Inquiry Response from Age Connects Morgannwg
February 2025

1. Overview of our hospital discharge services

Age Connects Morgannwg is a charity for older people living in Rhondda Cynon Taf, Bridgend and Merthyr Tydfil. Since 1977, we've been working to get older people the help they want, when they want it. We offer a wide range of information, advice and services to help older people stay living independently for as long as possible. Our work is designed to put you first and make life easier. Our dedicated staff and volunteer team offer independent and confidential information, advice and support on a variety of issues such as care, legal, health, housing, income and benefits, consumer, leisure, learning and work.

Age Connects Morgannwg has been commissioned by Cwm Taf Morgannwg University Health Board (CTMUHB) to deliver a hospital to home and preventative/dementia care service for over 20 years. The service has evolved over time but is essentially designed to ensure that older people, (aged 50 and over) receive support following discharge from hospital and receive ongoing short-term support at home, in an effort to reduce their risk of being readmitted. From 2012 until April 2022, the Health Board also funded the organisation to provide a Hospital Discharge Support Service. The service was delivered in Bridgend, Rhondda Cynon Taff and Merthyr Tydfil at Princess of Wales Hospital (POW), Royal Glamorgan Hospital (RGH) and Prince Charles Hospital (PCH). Currently we have the Trusted Assessor project which is funded by the Regional Partnership Board using Welsh Government's Regional Integrated Fund. It is a new project for Age Connects Morgannwg and focusses on supporting older people leaving hospital. The project supports the NHS Wales 6 Goals for Urgent and Emergency Care in Wales. The main aims of the project are to help older people to get home from hospital safely and get well at home, and to find out how older people experience the hospital discharge process. The project supports and facilitates discharges from hospital to local services through Discharge to Recover then Assess (D2RA) pathways, especially pathways 0 and 1.

Co-location within MDTs means we can engage with clients at the earliest opportunity to ensure patients are discharged effectively and efficiently; we are able to make decisions and solve problems quickly, and we have strong links with discharge co-ordinators and the Cwm Taf Care & Repair Trusted Assessor Team who focus on ensuring the patient's home environment is safe, accessible and warm. We have vehicles to aid rapid discharge, ensuring patients who require transport are taken home as soon as possible, accompanied by any small aids or adaptations to aid their rehabilitation. Using our purpose bought fleet has improved access, reduced costs, and improved patient experience.

Not only has this project helped improve NHS performance by assisting with quicker, safer patient discharges – it has also saved NHS staff clinical time by providing information about the home

environment and taking on a liaison role with the patient and their family. We cover this role for clinical staff, meaning they can effectively spend more time on-ward with their patients. We have added value to the patient journey and facilitated an improved patient experience by being a consistent point of contact both in hospital and at home. Between April 2024 and February 2025 we have supported 270 people home from hospital.

2. In Practice and Best Practice

At Age Connects Morgannwg, our Trusted Assessors report daily to Hospital Discharge Hub Manager on delays relating to ETOCs and Pathway 0/1 hospital discharge, within the three acute hospitals within our area of benefit. This service has identified that changes to packages of care, or new packages of care that are needed to be put in place for older people, routinely result in delays in discharge from hospital. Our Trusted Assessors who are independent of Health and Social Care Services, are able to provide a proportional assessment via a 'what matters' conversation to identify the support needs of older people. They are also able to operate a social prescribing function, as well as a support function whilst in hospital.

Our Trusted Assessors work with professionals to ensure patients have the equipment and information needed to get home safely. They work one to one with patients and support the coordination of discharge. They are available in acute sites, with the intention to develop their work in the rehabilitation sites. However, these posts are currently funded short term until September 2025. This makes project development difficult.

Community teams from local authorities, providing 6 weeks transitional care, home from hospital particularly Merthyr Tydfil, have been welcomed by patients and families

Age Connects Morgannwg's Better @ Home Service provides support to those patients who require practical and emotional support on return from hospital who do not qualify for a package of care. Our Better @ Home support workers are often finding people in living in inappropriate home environments, where due to issues like hoarding, self-neglect, mental health or frailty are not able to create a healthy or positive living environment at home. These teams often find that onward referrals for continued support to social work teams once someone is home are a lengthy process, leaving people in living situations which can often result in returns to hospital.

3. Case Studies

Carers in Hospital
One of our Trusted Assessors supported a long-term carer who was unexpectedly admitted to hospital. His wife had dementia and needed emergency respite whilst he was in hospital which was costing him £1000 a week. This was creating stress and distress and resulted in a longer admission than he needed.

Our Trusted Assessors are able to support carers in hospital to know their rights; ensure they have an assessment; and are able to effectively support and signpost them to relevant services.

As a result of the advocacy work of the Trusted Assessor, the client was discharged to the same care setting as his wife, enabling them to receive support together while he continued to recover.

Communication
Part of the Trusted Assessor role is providing improved communication between busy health and social care teams and the patients and their family. In one case where a patient was refusing discharge, the Trusted Assessor was able to work with them, the PALS team and the health care

professionals around the patient to help them understand their concerns about leaving hospital. A home visit identified issues with the home, and discussions with the patient who had learning difficulties and autism, identified a fear of not being able to feed himself. His parents had passed away, who had been his main carers, and he was struggling to communicate his feelings. The Trusted Assessor supported the patient to access OT support, a nutrition course and worked with an existing support worker to reinstate a relationship. The Trusted Assessor organised support from Care and Repair to bring the house up to standard and improve access to the kitchen and to create a safe sleeping area. All of this enabled him to be safely discharged home.

Where home accommodation is no longer suitable
Trusted Assessors have recently supported a gentleman in his 50s whose home was deemed unfit for habitation during his hospital stay. He was admitted to hospital with an infection and other issues. He was initially discharged home, but the ambulance service refused to let him stay due to the unsafe condition of his home. On return to hospital, Trusted Assessors were asked to go out to the property with Care and Repair to understand the situation better, and to see what changes needed to be made to get his home to a safe habitual state. They were able to advocate for his transfer to temporary accommodation whilst repairs were undertaken. Unfortunately he was placed in a B&B by the local council, which was inappropriate for his needs, as this was the only option available.

Isolation and Loneliness
A client on our Better @ Home project, referred via our Trusted Assessor scheme, frequently attends A&E. She is in her 90s and lives alone, with no family in the local area and her best friend recently passed away. Our support worker visits once a week and takes her out shopping. However, once the 6 weeks of support finishes, there is no ongoing services in the area for the client to access as she is unable to go out alone due to her mobility issues. This will likely result in a return to calling 999, ambulance service use and A&E time.

External delays
One patient we supported was unable to leave hospital for a period of two weeks after being clinically optimised for hospital discharge as she did not have the keys for her housing association flat due to the emergency and unplanned nature of her admission to hospital. One of our Trusted Assessors was able to liaise with the housing association (something the hospital teams had been unable to do) and the patient was discharged later that afternoon.

Waiting to go home
A client we supported who was in her 90s was waiting to leave hospital with a package of care in place. In her time of waiting to be discharged after being clinically optimised, she contracted hospital acquired COVID. A Trusted Assessor visited her daily to check in on her and chased up progress with Social Workers and other Allied Health involved in her care. This lady had no visitors as her family lived aboard, and her friends couldn't make the journey to visit her. Unfortunately, she passed away in hospital, alone.

Funding for adaptations
Funding for adaptations for Care and Repair - lack of capital funding for Care & Repair Agencies to install the necessary aids and adaptations in someone's home, has meant delays for people to get home from hospital, or people waiting to get home.

4. Final comments

Age Connects Morgannwg would be delighted to be involved in the conversations around how to improve hospital discharges and addressing delayed transfers of care, and how services such as our Better @ Home Service and Trusted Assessor Service can work alongside Local Authorities to

improve the experiences for older people. The Third Sector is a key partner in health and social care provision, often providing supplementary and preventative support to local authority and NHS partners, however we operate in a short-term funding culture with annual funding agreements. Short term funding results in services being decommissioned, despite them evidencing impact and positive change for both the service recipients and delivery partners.