HD 15
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: Cydffederasiwn GIG Cymru
Response from: Welsh NHS Confederation

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
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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.