

HD 17

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: Cymdeithas Geriatreg Prydain

Response from: British Geriatrics Society



John Griffiths MS
Chair, Local Government and Housing Committee
Senedd Cymru
Cardiff Bay
Cardiff
CF99 1SN

28 February 2025

Dear Mr Griffiths,

The role of local authorities in supporting hospital discharges – Submission from the British Geriatrics Society

The British Geriatrics Society (BGS) welcomes the opportunity to contribute to the Local Government and Housing Committee's inquiry into the role of local authorities in supporting hospital discharges. The BGS is the membership organisation for all healthcare professionals engaged in the treatment and care of older people across the UK. Since 1947 our members have been at the forefront of transforming the quality of care available to older people. Our vision is for a society where all older people receive high-quality patient-centred care, when and where they need it. We currently have over 5,300 members across the UK, including 260 in Wales.

This submission has been prepared by BGS Wales Council after consultation with members working across Wales. We have, where possible, illustrated our points with anonymised case studies. These are based on real patients and scenarios that our members have encountered in their work.

Scale of delayed transfers of care

The most recent data about delayed discharges states that across Wales, around 1,500 people experienced delayed transfers of care in January 2025. The largest proportion of these people (691) faced delays for assessments including waiting for a social worker allocation, awaiting completion of assessment by social care and waiting for continuing healthcare assessments. A further 295 were waiting for care home placements to be arranged and 129 were waiting for home care to be arranged.¹

Hospital data reveals in some departments around one third of beds are occupied by people who are ready to be discharged from hospital. Many of these are older people with frailty with significant support needs. The delays in facilitating discharge are shared across partner organisations but in our response, we will focus on those within Housing and Local Authority influence.

Delays in hospital discharge lead directly to poor care experiences for those patients who remain in hospital unnecessarily including exposure to airborne infections, physical deconditioning and deteriorating mental health. More widespread consequences include fewer ambulances available for emergency care as ambulances remain outside the

hospital waiting, patients who are cared for in corridors and other temporary care settings, financial consequences of the ongoing provision of hospital care, cancelled operations and an inability to address the elective backlog.

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

Availability of appropriate housing

BGS members report a lack of appropriate housing for older people living with frailty. Older people who are living in poor conditions may have no heating or electricity at home or live in unsanitary conditions. Necessary improvements often take time to arrange and older people are unable to be discharged in the meantime, which means that they remain in hospital rather than returning to their home.

Older people who have undergone major surgery in hospital, including amputees, face even longer waits in hospital as their previous housing may be unsuitable for their new needs, hence they need to be rehoused or adaptations made to their existing housing. BGS members report that even relatively simple adaptations, such as installing handrails, can take some time to arrange particularly where local authority housing is provided through private landlords. While patients are waiting for alternative housing or adaptations, they are unable to leave hospital, contributing substantially to discharge delays.

Case study

A patient who was due to undergo an amputation was referred to housing in late 2024. Their current property would be unsuitable for them as a wheelchair user as they would not be able to access the kitchen, bathroom or to leave the property. The patient was ready for discharge in early January. The patient is still on the highest re-housing priority list. However, as of mid-February, the patient and the ward team have had no update and have no sense of when discharge will occur.

Clinical teams often have good contacts with housing officers who are based in hospitals, but once the wider service is involved information does not seem to flow and situations as described above result, as a consequence patients are being kept in hospital long after they are ready for discharge.

Social worker delays in hospital

Involving a social worker early when an older person is admitted to hospital is key in ensuring that the individual is not unduly delayed when they are ready to be discharged. Often social workers are not involved in an individual's care until they are ready for discharge. There is also sometimes a disconnect between when clinical staff in hospital feel the input of a social worker would be beneficial and when the local authority is able to provide a social worker. BGS members report many circumstances where a patient after waiting to see a social worker becomes unwell and the referral is closed as the patient is now too unwell to be seen despite recovery being anticipated and the need for care support remaining.

Case study

A patient in hospital is prescribed a course of two weeks of intravenous antibiotics. The patient requires monitoring and assessment throughout their course of antibiotics but is recovering well and the medical team is able to say when the antibiotics will be finished and when the patient will be ready to be discharged. Despite this, social services are not involved in the patient's care until the antibiotics are finished. Only on the day the patient is ready to be discharged are social services actively involved in planning the discharge.

Involving social workers at the front door of a hospital can be transformative; Comprehensive Geriatric Assessment (CGA) is an evidence-based tool which enables continued care at home and reduced mortality by a multidimensional assessment of need. Complex social care domain assessments are best done by staff skilled in social care provision. When they are involved in a patient's care from the beginning of the process they can inform and advise on known issues in the community and start planning for discharge from the point of admission. BGS members working in services with a social worker at the front door report that it has made a considerable difference to discharge processes and has improved patient experience for older people attending hospital. Prompt multiagency CGA reduces long term care costs and improves outcomes.

There also needs to be greater interface between community based social services and hospital based social services. BGS members cite examples of patients, particularly those with long term mental health conditions, who have social workers in the community. In some cases, the patient has had the same social worker for many years; the social worker knows the patient well and can inform and advise on support needs and prior experiences. However, once the patient is admitted to hospital it is usual that the established community based social worker is no longer involved, instead the patient is assigned a hospital social worker, who does not know the patient background and who needs to restart the process of assessment.

Health Board and local authority boundaries also cause inequity of access to social services. It is not uncommon in Wales for one Health Board to cover two or more local authorities or for patients to be admitted to hospitals outside of their local authority boundaries. With social workers unable to undertake assessments on behalf of other authorities and few health providers holding a trusted assessor relationship, patients are unable to access timely assessments and have to move to a hospital closer to home, even though in many cases they are ready for discharge from the hospital. This causes distress for patients and is inefficient for the whole system.

Availability of care packages

A workforce shortage in community care means that older people living with frailty experience delays in receiving home care. Due to service pressures social services will not commence assessments until a person is deemed ready for discharge. This means that patients and families are remaining in hospital longer than would be optimal for their care. Once seen and assessed they still remain in hospital waiting for a care package to be provided in the community. Whilst some receive prompt short-term care through community resource teams (which are often "joint-funded"), those needing longer term care provision will typically face multiple consecutive delays. These delays are composed include waiting to be able to refer for local authority assessments, delays in completing referrals, delays due to social worker allocation and availability, appropriate time to complete needs assessments, preparation and contracting and then organising the provision of care. During this period of delay older people in hospital will often face deterioration in terms of both mental and physical health, inevitably contributing to higher levels of care need.

In addition to causing delays upon discharge, shortages in social services can mean that people are admitted to hospital who do not need to be there in the first place. Caregivers are often older relatives themselves with their own health concerns and become unwell or find that they are unable to cope with delivering care on an ongoing basis. Their loved one is then admitted to hospital unnecessarily.

Case study

A man living with dementia resides with his son who is over 70 years of age. Whilst they have been coping without any support the father starts to experience incontinence and the son contacts social services to ask for help to meet his father's care need. He is initially told that there would be a wait of eight weeks for an assessment from a social worker. Towards the end of the eight-week period, the father starts to fall and the son contacts social services again only to be told that there would be a further wait. The son is unable to cope with his father's increasing care needs without help and as a result the father is admitted to hospital, despite not having an acute illness. If support from social services had been available, the hospital admission would have been avoided.

A lack of appropriate care home places can mean that when places are available, they are far away from the individual's home, family and social networks. This is a particular issue for people with dementia and who require specialist care.

Case study

A patient from a community in the Welsh Valleys has been admitted to hospital with an acute illness. He has dementia and upon discharge he requires specialist care which cannot be delivered at home. He needs a place in a specialist dementia care home which can cater for his needs. Due to a lack of local facilities, he has a prolonged hospital stay and when discharged, it is to a care home 50 miles from his home, his family and his community.

There is a need to ensure equity of access to appropriate care particularly for those from rural communities.

Training and recruitment of social care staff

Care work is skilled work and should be paid and valued as such. Caring for older people, especially those with dementia and other cognitive impairments, is challenging and it is essential that the motivated people recruited to do this work are trained and supported appropriately. There are many agencies providing high quality person-centred care but unfortunately too many people have experienced unreliable or poor-quality care. This can mean that older people who are admitted to hospital can be reluctant to accept necessary care or to leave hospital when they are ready to be discharged.

Legislative barriers*Court of Protection*

Patients who require the involvement of the Court of Protection face the longest delays in being discharged from hospital. While this affects a relatively small number of people, those people face delays; often waiting more than a year before they are able to be discharged. BGS members estimate that each hospital in Wales will have around five patients who have been in hospital for more than six months because they are waiting for a Court of Protection decision with many colleagues reporting typical delays of more than 12 months. For efficient joint preparation and submissions to the Court of Protection it is essential that staff experienced in case preparation work collaboratively and in a person-centred manner to prepare evidence in a timely manner.

Continuing healthcare

Delays with deciding whether an individual's care will be the responsibility of the local authority or the NHS (e.g. continuing healthcare) can cause significant delays to discharge. Such assessments are best undertaken in the community (discharge to

assess). Many teams work well in ensuring this can proceed but there are many examples where setting in place care to support a community assessment is delayed. In some cases, this means that a patient dies in hospital while waiting for a decision.

Case study

A patient is in hospital and is almost certainly in the last three months of life and wants to go home. The patient has previously had a local authority package of care which has been withdrawn while a decision is made about their eligibility for continuing healthcare. This means that they are unable to leave hospital until a decision is made, even though their care needs have not changed.

Concluding comments

There are many examples of care provision that works well across agencies, providing person centred care and prompt assessment and support. With increasing numbers of older people living with multimorbidity and/or frailty the need for such services is increasing.

Housing issues and discharges that require representation to the Court of Protection impact on a small number of individuals, but these cause extensive delays to discharge processes.

Many older people face delays in facilitating their discharge. This has adverse impacts in terms of both their physical and mental health and is directly linked to functional decline. These discharge delays lead to increased costs for the health service and higher levels of care support need for the local authority. In some departments up to a third of hospital beds are currently occupied by people who are ready to be discharged (Jan 2025). Addressing these delays would make a significant difference to the experience of those patients directly affected while also enabling the entire system to operate more efficiently. We know that if systems work for older people living with frailty, they are more likely to work for the rest of the population.

Thank you for the opportunity to submit written evidence to the Committee. We would welcome the opportunity to give oral evidence to the Committee to discuss these issues in further detail. Please contact our Policy Manager, Sally Greenbrook (s.greenbrook@bgs.org.uk) to arrange for a BGS Wales Council member to attend an oral evidence session.

Yours sincerely

Dr Karl Davis
Chair, BGS Wales Council
Consultant Geriatrician, Cardiff and Vale
University Health Board

Dr Nicky Leopold
Vice-Chair, BGS Wales Council
Consultant Geriatrician, Abertawe Bro
Morgannwg Health Board

¹ <https://statswales.gov.wales/Catalogue/Health-and-Social-Care/NHS-Performance/pathway-of-care-delays/pathwayofcaredelays-by-reasonfordelay-date>