

HD 24

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: Coleg Brenhinol Therapyddion Galwedigaethol

Response from: Royal College of Occupational Therapists

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About us

We're RCOT, the Royal College of Occupational Therapists. We've championed the profession and the people behind it for over 80 years; and today, we are thriving with over 35,000 members. Then and now, we're here to help achieve life-changing breakthroughs for our members, for the people they support and for society as a whole. Occupational therapists in Scotland work in the NHS, Local Authority social care services, housing, schools, prisons, care homes, voluntary and independent sectors, and vocational and employment rehabilitation services.

Occupational therapy helps you live your best life at home, at work – and everywhere else. It's about being able to do the things you want and have to do. That could mean helping you overcome challenges learning at school, going to work, playing sport or simply doing the dishes. Everything is focused on increasing independence and wellbeing.

It's science-based, health and social care profession that's regulated by the Health and Care Professions Council.

An occupational therapist helps people of all ages overcome challenges completing everyday tasks or activities – what we call 'occupations'. Occupational therapists see beyond diagnoses and limitations to hopes and aspirations. They look at relationships between the activities you do every day – your occupations – alongside the challenges you face and your environment.

Then, they create a plan of goals and adjustments targeted at achieving a specific set of activities. The plan is practical, realistic and personal to you as an individual, to help you achieve the breakthroughs you need to elevate your everyday life.

This support can give people a renewed sense of purpose. It can also open up new opportunities and change the way people feel about the future.

The role of occupational therapists in social care

OTs are integral to the success and sustainability of social care services. They enable people affected by long-term illness and disability to participate in a wide range of daily activities (occupations). This includes supporting people to maintain or regain independence in tasks such as personal care, meal preparation and household chores. It also includes enabling people to fulfil their work and caring roles. By delivering elements of the Social Services and Well Being Act, they play a paramount role in preventing, reducing and delaying the need for statutory services and meeting the profound care needs of the population.

Occupational Therapy is integral to the delivery of the Welsh Government (2025) hospital discharge guidance. The guidelines state there must be simple, robust and responsive pathways to discharge. The guidance states that occupational therapists (OTs) in local authorities should be deployed flexibly to support patients on the relevant D2RA pathway.

OTs play a vital role helping people overcome challenges completing everyday activities. They assess individuals using a person-centred approach to identify their needs and work co-productively to agree the goals that people wish to achieve. Their interventions enable people to thrive and live fulfilling lives. OTs in social care work in adults', children's and housing services, as well as in learning disability teams, prisons and in public health.

Despite being a linchpin in the social care system, OTs remain under-utilised. Where Councils are not positioning occupational therapy prominently, they are missing out on substantial cost savings from preventative interventions and the best possible outcomes for people and budgets. Inaction on adult social care reform has put occupational therapy services under considerable strain. The RCOT workforce survey 2022-23 found that 78% of OTs felt their team wasn't large enough to meet demand, with 63% saying they were too busy to provide the level of care they'd like (RCOT, 2023)

The impacts are not limited to the individual, with families and loved ones also affected. Where a person's support needs increase, family members are often relied upon to provide informal care, which can strain their ability to manage their own responsibilities, including work and parenting. The Hospital Discharge Guidance states that local authorities must deploy occupational therapy flexibly to support hospital discharge. This has led to several different arrangements throughout Wales where OTs work in regard to hospital discharge. Some councils have local authority OTs in joint council/health community resource teams. In Flintshire for example reablement offers support for hospital discharges by in-reaching to hospitals to ensure a proportionate package of care is set up to enable the person to be discharged home quickly. Where this is not possible, the person is discharged to a STC/D2RA bed where assessments can be completed by the therapy team to ensure discharge home is with the suitable package of care and reduce pressure on acute beds.

Some councils such as the Vale of Glamorgan have also focused on training staff in the Trusted Assessor Pathway led by the Vale Community Resource Service (VCRS).

What is established

A Trusted Assessor training programme (delivered by VCRS staff) for in-patient staff across Cardiff and the Vale UHB. The training programme is delivered by VCRS staff who are an integrated team of health and social care OTs. They also play a pivotal role in case management and care coordination at the forefront of the inhouse reablement service.

The aims of the service are:

- In-patient Trusted Assessors complete proportionate and strength-based assessments on behalf of VCRS and identify the essential care and therapy needs for a safe discharge
- Once proportionate and strength-based assessment is completed, the request is sent to VCRS via e-referral and is passed directly to the Care Co-ordinators for care scheduling

- Reduced duplication of assessments between hospital and community services- thus streamlining discharge planning and improving trust and communication
- Timely 'what matters to me' conversations in the hospital and improved patient experience through more co-productive care planning
- To date there are 50 Trusted Assessors (OTs and physiotherapists) across all clinical sites within Cardiff and Vale UHB- including A+E
- Current figures show that Trusted Assessor referrals make up 15.2% of referrals accepted for VCRS reablement (18% when excluding those who were not discharged due to being medically unfit)
- Training programme to continue to be rolled out, to also include specialist nurses e.g. frailty nurses, clinical specialists
- Improved knowledge and understanding of VCRS with overall improvements in quality of referrals through the Trusted Assessors cascading principles of the training to colleagues and junior staff

Case Studies

Case Study 1.

Ann presented to A+E following a fall and with a chest infection. Daughter expressed carer strains as she had found it impossible to meet her mother's current care needs due to acute illness and frailty. A proportionate and strength based assessment was completed by the in-patient Physiotherapist (Trusted Assessor) and same day response was actioned by VCRS and care commenced later that day. An Occupational Therapist from VCRS visited this day to complete the necessary functional assessments in the home environment prior to care commencement. A temporary keysafe and rollator zimmer frame was provided by VCRS to ensure swift return home. A personalised plan was also developed in collaboration with Ann and daughter. Due to acute illness Ann was initially supported with all transfers and mobility in a micro environment and received four care calls daily alongside support from the daughter. Once settled at home, VCRS Physiotherapists visited and progressed Ann to mobilising short distances with rollator zimmer frame. This progress was incorporated into the personalised plan and she continued practising walking under the supervision of Reablement Support Workers. She started participating more and was then able to access her bathroom and garden. Ann continued to go from strength to strength and the reablement support was gradually reduced and daughter was able to resume caring duties. Outcome- Ann was supported by Reablement Support Workers for a total of 16 days and received Occupational Therapy and Physiotherapy input for a further 4 weeks.

Case Study 2.

Margaret is an 84 year old lady who was admitted to hospital with non healing leg ulcers which became infected. She lives with her husband who has dementia for whom she was a main carer and she was keen to get home as soon as possible. A comprehensive referral was received from a Trusted Assessor which clearly identified the care needs. Within 2 hours of receiving the referral, discharge plans were already confirmed with the ward. Margaret was able to be discharged home the same day with family support until care support could commence the following day. Margaret

was visited in her home by the Occupational Therapist (OT) who completed all the relevant documentation and functional assessments. Margaret's goal was to be able to care for her husband and to not have to rely on care herself long term. OT identified that Margaret would benefit from a carer's assessment and Margaret agreed to the onward referral. District Nurses were also supporting with re-dressing of legs. Margaret received a daily morning care call for support with personal care. She was keen to shower as soon as possible and OT supported Margaret with obtaining a waterproof cover following consultation with the District Nurses. Long handled aids were also issued to support lower body washing and dressing and care staff practised using them with Margaret.

Outcome- Within 2 weeks of being home, Margaret was able to complete her own washing and dressing independently but due to lacking in confidence was reluctant to withdraw the care support. A gradual reduction was made to care calls to every other day until after 1 further week, Margaret was happy to stop care. Margaret was very thankful for the equipment and also confirmed Social Services had been in touch to arrange a carers assessment.

- 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;

OT doesn't hold these figures, could be obtained with further time.

- 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;

Despite constituting only 4% of the regulated social care workforce, OTs intervene in around 35-45% of local authority referrals (RCOT, 2019a). Inaction has led to under-resourcing of OT services, which is significantly affecting many individuals accessing social care. Long waiting times to receive OT input can result in deterioration of people's health and independence, which in turn leads to an increase in their support needs. They may also be at increased risk of accidents such as falls, which can lead to a need for acute or emergency care. Both their physical and mental health can be affected, and they may be less able to participate in work or education. Additionally, they may be unable to fulfil important roles such as parenting and caring for others.

Our members report other issues that affect capacity:

- Some local councils have an embargo on posts therefore we have not been able to replace maternity cover within teams. Speed and motivation from councils to recruit is often slow and doesn't take priority
- In a rural area of mid, west and north Wales there is a chronic lack of available carers
- High demand for certain care calls (such as AM for personal care etc.) and lesser demand for other times can cause logistical difficulties for maximising capacity. resistance from care agencies at times to consider reducing or changing care provision following assessment.
- Variability across care staff/support workers in confidence/skills in some areas (MH, SHC, Reablement techniques)
- Care agency rotas – double runs etc. Also POC where there may be a request for DHC on some calls but SHC on others

- Possible over prescription of care for some hospital discharge. Culture – Ensuring everyone is ‘on the same page’ and transparent with citizens regarding care needs and assessment period following discharge. People report they have been told this is what they ‘need’ and are resistant to change once home as feel this wasn’t clearly explained.
- Limited communication at times, different note systems and lack of streamlined processes between health and social care
- Availability of equipment/adaptations/housing to support discharges can be an issue at times. Since Brexit ordering times have increased, cost of materials and availability of trades people are an issue
- Increased more complex cases and less ‘traditional reablement’ cases which can effect capacity and flow.
- Citizens refusing adaptations to support discharge due to personal choice (this also applies to citizens reviewed in the community)
 - waits for care assessments (and other assessment related issues)

Our members report that assessments can be completed quickly by the reablement team, prioritised, triaged and allocated within a week of receiving the referral. If urgent this will be allocated the same day (when we have full team) however problems arise for a number of reasons

- Timely allocation to Social Work teams can be problematic
- Referral for care packages prior to citizens reaching full potential, this leads to overprescription of equipment and care packages. Inappropriate referrals – occasional issues at screening for reablement and ensuring citizens are appropriate for service
- Struggles to implement effective co-production of Care and Support Plan’s between therapies and social workers. The POC is arranged and led by SW and not OT therapy which can cause conflict when attempting to right size the POC. The frequency and length of calls are often adjusted once home.
- - challenges in arranging care home placements or home care packages, and
 - disagreements or legislative barriers affecting discharge decisions;

Therapy-led programmes enable systems to review their approach to moving and handling, ensuring that care packages are proportionate to the person’s needs. This promotes participation in daily activities, enables people to be discharged from hospital sooner, and reduces demand upon domiciliary care.

Our members argue that social services and well being act states they should complete right response first time, this is not the case. More often than not the person’s POC is reduced and this is a waste of initial resource/capacity, and causes conflict with person, care agency and family when reducing the calls.

It can be difficult to right size the POC when the person is awaiting discharge or is ready for discharge as therapy within Hospital setting can feel undermined by Social Care OT/Physio assessing. There are several reasons why there is a difference in opinion which can cause conflict; HOT (Hospital OT) does not have access to single handed care equipment, there is no follow through with the single handed agenda from Nurses or HCA on the ward, OT within hospital setting are not familiar with the context of the home environment (often we know the person and the home

they live in)

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