Llywodraeth Cymru
Welsh Government

Local Government & Housing Committee

The Role of Local Government in Supporting Hospital Discharges

07/05/2025

Hospital discharges are a critical component of patient care, ensuring that individuals transition smoothly from hospital to home or another care setting. Local government play a pivotal role in this process, particularly through the role of their social services departments.

This paper explores the various ways local government provide vital support to the hospital discharge process, as well as the ongoing challenges, and the future support and closer ways of working we seek to adopt to jointly overcome these obstacles.

Contents

Local Government – Key Social Care Functions

Local government partners provide a range of social care services, including home care, community support, and residential care placements. These services are essential for some individuals who need ongoing assistance with daily activities and care after leaving hospital.

Local authorities, primarily through social services, work to ensure safe, timely, and efficient discharges from hospitals.

Coordination of Care

Effective hospital discharge requires seamless coordination between local government social services and healthcare providers.

Assessments

Local Government is responsible for assessing the care needs of patients who are ready to be discharged from the hospital. This involves evaluating the patient's physical, emotional, and social needs to develop a comprehensive care plan that ensures their safety and well-being at home.

Domiciliary Support

Domiciliary support is the provision of care and support to people due to their vulnerability or need at the place where they live. Local government may commission domiciliary support services or provide them directly. Domiciliary support services are regulated under the Regulation and Inspection of Social Care (Wales) Act 2016.

Reablement

Reablement is defined in regulation 1 of the Care and Support (Charging) (Wales) Regulations 2015, as care and support provided or arranged by local government, for a specified period, enabling persons to maintain or regain the ability needed to live independently in their only or main home. Regulation 4 prohibits local government from charging for reablement services provided for a period of up to six weeks.

Residential Care

Care home services provide accommodation, together with nursing or care, in Wales to adults and children because of their vulnerability or need. Local government may commission care home services or, where they do not include nursing, provide them directly. Care home services are regulated under the Regulation and Inspection of Social Care (Wales) Act 2016.

Intermediate Care Services

Intermediate care services, which are run by local government, for a period of no more than 16 weeks per individual, are exempted from having to register as a care home service, if the care and support is provided by the area's registered domiciliary support provider and the accommodation is vested in the local government.

Joint working arrangements between Local Government and Welsh Government

Local Government are a key partner and vital contributor to the development of a number of policy initiatives aimed at supporting hospital flow and discharge.

Local Government Support in Developing Discharge Reporting

Formal reporting on hospital flow and discharges had previously been suspended during the pandemic along with several other NHS reporting mechanisms to allow staff to focus on delivering care to patients. In 2022 work commenced to reinstate a reporting framework to begin to record discharge delays. The opportunity was taken to not only restart reporting but to consider ways that we could improve on our data collection.

The reporting framework was developed through 2022 via a joint Expert Group, co-chaired by Welsh government and NHS Executive (formerly NHS Delivery Unit at the time) and comprised membership from health board discharge teams, Digital Healthcare Wales (DHCW) and the Association of Directors of Social Services (ADSS Cymru). We utilised this collaborative approach to the development of the framework to ensure that we had cross-sector input into the development of the new reporting structure. Members discussed and agreed the key decisions undertaken as part of the new framework such as:

- The definition of a delay – the previous reporting system lacked a standard definition for delays, causing variations in reports. It was agreed that a uniform definition will ensure consistency and comparability.
- Timeframes for reporting a delay – alongside the updated definition to record a delay it was agreed that the timeframes included should be attainable but challenging. The Expert Group recognised that we should balance the need to support people to leave hospital promptly, when ready for discharge, against the processes needed to achieve this. This was supported with links to the *Discharge to Recover then Assess* (D2RA) process, which directs staff to allocate patients to a suitable discharge pathway based on their likely ongoing need at discharge and then commence the process to engage those services at the earliest opportunity during the patient's admitted period, rather than leave these to begin once the patient is ready for discharge.
- The delay codes – the Group agreed the full list of updated codes which would present us with a comprehensive list of reasons a person might be delayed. These codes would then help us to review and coordinate efforts on specific processes in each region.

In 2023 we launched a revised approach to collecting hospital discharge data. The *Pathways of Care Reporting Framework*. The new framework was developed with the joint aims to:

- improve patient outcomes.
- benefit service providers and teams.
- be utilised as the key data source to deliver meaningful actions aimed at improving patient outcomes, reduction of system delays and development of services at a regional level.
- provide validated data on discharge performance for All Wales service development and planning purposes.
- provide an expanded reporting framework for Welsh Government, NHS Executive and Ministers.

Local government was instrumental in helping us to develop this work programme and it was recognised at the start of the process that this should not be a reporting framework that was developed in a vacuum. The Expert Group that was established to design the new framework was considered a beneficial collaborative space between health and social care. It was agreed at the request of the membership that the work of the Group be continued beyond the April 2023 implementation date.

The Group has since transitioned to the Development Group that reviews the ongoing utilisation of the reporting framework on a process of continuous improvement. The Group have also been involved in several other initiatives related to hospital discharge performance such as work via the Care Action Committee and the recent 50-Day Integrated Community Care Winter Challenge.

Local government representation remains an essential partner in the ongoing work programme as we continue to explore how we improve and expand hospital discharge and patient flow processes.

Partnership arrangements

In Wales, partnership arrangements for health and social care are guided by Part 9 of the Social Services and Well-being (Wales) Act 2014. This legislation emphasises collaboration between local government and local health boards to improve care and support services. Key aspects include:

- Regional Partnership Boards: These boards are established to ensure that health and social care services are integrated and meet the needs of individuals. They focus on improving outcomes, promoting well-being, and making efficient use of resources.
- Pooled Budgets: Resources are often combined to deliver integrated services effectively.
- Person-Centred Care: The approach prioritises giving individuals more control over their care and ensuring services are coordinated to meet specific needs.

The five-year (to end March 2027) Health and Social Care Regional Integration Fund (RIF), with an annual allocation of £146.2m is allocated to the seven Regional Partnership

Boards (RPBs) to develop six models of integrated care, one of which is Home from Hospital.

Home from Hospital services require health and social care to work together to facilitate timely discharges. They work closely with multi agency Community Resource Teams (CRTs), which facilitate co-working across health, social care, and the voluntary sector to help people safely return home from hospital and to enable their recovery within the community. In some CRTs, they work closely with Falls Prevention Teams and with GP practices.

In 2023/24 *(2024/25 figures currently being finalised at year end*), the RIF allocation for this model of care was £34m across a range of health, social care and third sector projects including hospital discharge provision/teams, supporting unpaid carers and voluntary sector Home from Hospital support services. This equates to 28.2.% of the total allocation of the RIF.

The RIF also funds models of care that are preventing people's health and care needs from escalating and avoiding preventable conveyance and admission to hospital. For example, the Complex Care Closer to Home model is funding projects (involving local government) and supporting people with more complex needs to remain and have their care needs met at home. The allocation for this model, across the RPBs is £20.6m (equating to 17.1% of the RIF).

The Community Co-ordination Model of Care is also assisting with building capacity in our system with £32.8m (27.%) being allocated to projects and services. This model focuses on prevention and early intervention with activities such as social prescribing and community-led support being core components as well as micro-enterprise home support and falls prevention services to ensure that people are able to stay at home without the need for a secondary care intervention.

50 Day Integrated Care Winter Challenge and Care Action Committee

In July 2024, the Ministerially led Care Action Committee set 3 national ambitions for health and local government partners to jointly achieve:

- Reduce pathways of care delays (PoCDs)
- Increase district and palliative care nursing hours on weekends
- Increase the count of people (at home and in care homes) benefiting from step care as a safe alternative to conveyance/hospital admission, and step-down care from hospital

To accelerate the work needed to achieve these ambitions, Care Action Committee launched the 50 Day Integrated Care Winter Challenge on the 11th November 2024.

The Challenge provided health and social care partners with 50 days to review and evaluate their systems against 10 best practice interventions and to make necessary improvements (including the aim to reduce PoCDs). While some of these interventions will take longer to fully implement, each health and social care partner developed a clear understanding of their performance and a shared action plan by the end of the Challenge.

Local government played an equal role with NHS partners in delivering services that aligned with the majority of the 10 best practice interventions e.g.

Intervention 1 - Refresh focus on embedding the Optimal Hospital Flow Framework to include a proactive emphasis on rehabilitation and reablement across the Health & Social Care system.

Intervention 2 - Apply 7-day Health & Social Care working to enable discharge of patients during the weekend.

Intervention 4 - Regional collaboration to ensure that 'integrated navigation hubs' exist to facilitate discharge for acute hospital sites and admission avoidance in the community.

Intervention 5 - Regional Health & Social Care weekly review of Lengths of Stay (LOS) 21-28 days and 20 longest LOS patients with focused actions to progress discharge.

Intervention 8 - Trusted Assessor model for all care settings.

Intervention 9 - Home First default for all patients clinically optimised – Health and Social Care discharge planning begins on admission.

Intervention 10 - Integrated community services to focus on 7-day community-based falls response pathways.

To achieve success in these areas of work, no single organisation or sector can drive meaningful change alone; it's the collective effort between health and social care and the wider third sector partners that makes a difference. This shared responsibility is vital, not only to tackle immediate issues like PoCDs, but also to strengthen community provisions that proactively reduce the need for hospital admissions. This can be achieved through the implementation of the Integrated Community Care System (ICCS) for Wales.

Integrated Community Care System for Wales

The developing Integrated Community Care System (ICCS) is intended to deliver on the ambitions of *A Healthier Wales*. It aims to enhance the health and well-being of the people of Wales by integrating health and social care services, increasing care and support options for people in the community as a safe alternative to hospital admission and support timely discharge from hospital when further care and support in the community is needed.

The first iteration of the ICCS blueprint was developed through cross-sector work, under the Rebalancing Care and Support programme as part of the work to clarify and strengthen the role of RPBs. Local authorities were a key stakeholder in its development and have been an active participant in developing the ICCS since its inception.

The ICCS is designed to unify the objectives of the three major health and care programmes in Wales: the Six Goals for Urgent and Emergency Care (UEC), the Strategic Programme for Primary Care, and the Regional Integration Fund (RIF). Additionally, the "Building Capacity through Community Care – Further Faster" initiative and learning from the 50-Day Integrated Care Winter Challenge supports the vision of integrated community care.

Partnership working to tackle Pathways of Care

In 2024 we engaged with regional partners to set out trajectory targets to reduce hospital discharge delays. The trajectories were discussed and agreed through the Care Action Committee, which is chaired by the Cabinet Secretary for Health and Social Care and comprises members from health boards and local government.

The ambition with the trajectories was to set challenging but realistic targets for regions to work towards jointly, and we're focused on the 3 key aims of the total number of delays, the total number of assessment related delays and the total number of days delayed. The Pathways of Care Delays trajectory targets set for 2024/2025, along with outcomes in March, were to:

- Reduce total delays by 15%, which has been exceeded with a 17% reduction achieved.
- Reduce specific assessment related delays by 20% was exceeded, with a 22% reduction achieved.
- Our target of reducing total number of days delayed, also set at 20%, has unfortunately not been achieved, however we have seen a 12% reduction on the baseline for the target.

Oversight of progress was maintained through a combination of the Care Action Committee meetings and monthly regional meetings with health and social care teams. These provided us with the opportunity to review activity and explore examples of best practice and partnership working. The progress towards the targets was also supported through the interventions within the 50-day challenge outlined above. This was also supported with £10m in funding to local government over the winter period to increase community capacity and reablement services.

These initiatives helped to support and focus regional partners, including local government, to improve discharge support services and community services which tackled the dual purpose of supporting discharge processes and front door admission avoidance.

Through this action we saw an improved approach to discharge delays over the winter period where, historically, we had seen significant incremental increases in discharge delays in the January to March period. From December 2023 to March 2024, we saw a rise of +300 delays, however for the December 2024 to March 2025 position we have reported a reduction of -52.

Local government teams were vital in the delivery of progress towards the trajectory targets. Of the 278 reductions of discharge delays that were achieved between March 2024 and March 2025, 199 of these were social care related codes. This represents over 71% of the improvements that we have seen in relation to the total number of delays.

The Scale of Challenges

In recent years we have introduced mechanisms to help us review and understand the trends, shape and scale of the challenges being faced by both health and social care sectors. These reports help us to determine where progress is being made as well as issues affecting service delivery. This information has been instrumental in helping us collectively determine the areas that need the most attention.

Social Care Performance and Improvement Framework Data

During the year 1 April 2023 to 31 March 2024:

- 125,112 contacts were received by statutory social services for information, advice and assistance (IAA) services for adults who were not receiving care and support, or support (as a carer) at the time of the contact. This is an increase of approximately 2% from 2022-23.
- 69,379 new contacts for adults received by statutory social services during the year were provided with advice or assistance. This represents about 55% of all new contacts in 2023-24 (where data was provided). In 2022-23, there were 70,256 new contacts which were provided with advice or assistance, representing about 58% of all new contacts in that year (where data was provided).
- 69,676 new assessments were completed for adults who did not already have a care and support plan, a decrease from 74,417 in 2022-23. Where recorded, 37% of assessments in 2023-24 concluded the adult had eligible needs which could only be met with a care and support plan, compared to 34% in 2022-23.
- 9,327 packages of reablement were completed by adults, compared to 8,666 in 2022-23. In 2023-24, 86% of completed packages reduced, maintained or mitigated the need for support following the period of reablement, compared to 83% in 2022-23.
- 25,492 reports of an adult suspected of being at risk (of abuse or neglect) were received, compared to 21,951 in 2022-23. Where the category of alleged abuse was provided, 34% of reports alleged abuse under the category of neglect (more than one category may be suspected in a report).

On 31 March 2024, 48,519 adults had a care and support plan. Of which, 13% had a care and support plan supported using a Direct Payment. In comparison, 47,428 adults had a care and support plan on 31 March 2023, of which 12% were supported using a Direct Payment (however one local government region did not provide data in 2022-23).

2024-25

Taking Wales as a whole over the past 12 months, the number of people in receipt of domiciliary care has increased, though the number of people waiting for domiciliary care has reduced on a national level.

An all-Wales overview of reablement shows an increase in the number of people receiving this service during the past 12 months and an increase in waiting lists.

It should be noted that this is based on local government data reported to Welsh Government and refers to the totality of delivery of domiciliary care and reablement commissioned or delivered by local government (not including care that is entirely self-funded). It does not solely refer to care delivered to people being discharged from hospital.

Pathways of Care Data

Overall, the key pressures and challenges that local government are facing, as identified through the Pathways of Care Delays monthly reporting data, is in supporting timely hospital discharge associated with:

- social care assessment functions,
- workforce provision and
- care capacity.

Predominantly, the availability of social workers to allocate to patients and subsequently undertake social care needs assessments has had an impact on the discharge process enabling patients to leave as soon as they are clinically optimised to do so.

In addition, local government's ability to provide or commission new home care packages, owing to limited availability, has impacted the discharge process and overall delays numbers. This is also the position with residential care home places and reablement care package that aid a person's post discharge recovery at home.

A collaborative approach between local government and health boards remains key to reducing discharge delay numbers and maintaining an improved position on tackling these and other joint led delay areas. Data has confirmed that over the current Pathways of Care Delays reporting year (ended March 2025), there has been a significant reduction in hospital discharge delay numbers related to social worker allocation and the completion of social care assessments, particularly over the final quarter. This is a very encouraging position in view of the additional pressures placed on services and staffing levels over the winter period.

Future Support and developing closer working relationships

As we continue to build on the joint successes, we have been able to deliver improvements to patient flow and hospital discharge. We will ensure that we are providing further opportunities to support the sector, work closely to form new partnership ways of working and co-produce future policy. We will work to support local government in their efforts to support people and patients.

£30m Pathways of Transformation Grant.

The services provided by local government are a vital component in the discharge arrangements for many people leaving hospital. The scale of demand and complexity of the support needed has been shown to be growing, and with the ageing demographics within many regions in Wales, it is only likely to increase in future years.

In recognition of the need for targeted support we are allocating £30m in 2025/26 through a Pathways of Care Transformation Grant to local government to boost investment in community-based social care.

The grant will support activity towards timely assessment and provide packages of care to ensure people can leave hospital when they are clinically optimised, helping to reduce the level of delayed hospital discharges. The fund will also be utilised to strengthen community-based care services to support people to stay well at home.

Enhanced Partnership and Collaboration – Local Government Strategic Partnership Agreement

We will continue to work closely with our local government partners to develop refreshed partnership arrangements through a strategic partnership agreement. The intention is that this will include a shared commitment focused on hospital discharge and pathways of care. The shared priority outcomes of this agreement are designed to drive fundamental and meaningful change in a number of key service areas which are important to the people of Wales. These outcomes will be monitored.

Adoption of Best Practices

There are clear benefits to adopting best practices and innovative approaches to hospital discharge. This includes implementing standardised assessment tools, utilising technology for care coordination, and learning from successful models across regions.

Care Homes Wales Project, local government are encouraged to use the public facing website www.carehomes.Wales and series of dashboards which present data about adult care homes and their vacancies. This project is funded by the Welsh Government and delivered by Data Cymru.

The Healthcare and Wellbeing Framework for care homes is being developed and will set out what good looks like in terms of healthcare and wellbeing services for people living in care homes. This will include how health services and social care services will work together to achieve better outcomes and seeks to embed ways of working that are prevention focused, promote more care being provided in the home, reduce the need for hospital admissions and establish mutually respectful, robust relationships across health and social care.

During the recent engagement activities we have undertaken with stakeholders, multiple examples of innovative best practice were shared and will be included in the framework document that is currently being drafted. We have agreed with stakeholders that we will establish a community of practice to support implementation of the framework, the sharing of best practice and exploration of how models of best practice could be scaled up.

The Strategic Domiciliary Care Group, comprising local government, health board and provider representation is working with the Welsh Government to identify means to increase the sustainability of domiciliary care in Wales. Workstreams are exploring aspects of commissioning and employment arrangements and the extent to which this may support staff retention and provider stability.

We currently provide £1m of ringfenced funding to health boards to ensure carer support services within hospitals and discharge guidance outlines the importance of involving unpaid carers in discharge planning. The Welsh Government provides additional funding for the training of healthcare staff to be more aware of the needs of unpaid carers. Local government fulfilling their statutory duties toward the support of unpaid carers is an important factor in their support of hospital discharges more widely.

Joint planning and commissioning between health and social care partners through Regional Partnership Boards (RPBs),
RPBs are well established and implementing statutory duties to deliver partnership arrangements in relation to joint planning, commissioning, collaboration and integrated working. RPBs are also required to produce annual reports which provide an opportunity to share learning and identify further good practice, which will support the strengthening of planning and commissioning arrangements.

There are further opportunities to increase planning and understanding of population needs through review of Population Needs Assessments. The National Office for Care and Support have published a national framework for commissioning care to deliver national principles and standards for commissioning care and support. The review of RPB Market

Stability Reports also provide opportunities to actively shape commissioning strategies and provider provision to secure the right services and support for people in the right place, at the right time.

There is continued investment from the Regional Integration Fund (RIF) through RPBs supporting joint commissioning arrangements as we move forward with an Integrated Community Care System for Wales, but longer-term consideration will be required when the fund ends in March 2027. The RIF is underpinned by the development of six Models of Care and is further supported by national Communities of Practice which bring partners together to share learning and provide an opportunity to upscale and share good practice across Wales.