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Care & Repair Cymru

The Role of Local Authorities in Supporting Hospital Discharge

Care & Repair Cymru

Care & Repair improves homes to change lives. We help our clients to live independently in warm, safe, accessible homes by delivering housing adaptations and home improvements. We offer a holistic casework service including a whole house assessment taken from a national framework, including a falls risk assessment, welfare benefits check and home safety information and advice. Our Hospital to a Healthier Home service helps speed up safe hospital discharge and reduce readmissions. Our specialist caseworkers work with hospital staff and patients to identify patients who are medically well but cannot go home due to a housing or environment issue to provide solutions to enable safe hospital discharge. In 2023-2024 17 caseworkers across 17 principal hospitals achieved:

- 5,027 referrals, 4,104 people we directly supported with safe hospital discharge;
- 7,561 home adaptations and improvements to enable hospital discharge;
- 2,592 additional Healthy Home Checks to ensure long term support and recovery at home;
- Over 24,000 bed days saved.

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

In recent years, we have seen a noticeable increase in the number of Local Authority employed staff in hospitals across Wales in roles designed to support hospital discharge. For example, we work a lot with the Home First Team in ABUHB, Delta and PIVOT in HDUHB, and have a presence in the discharge hub in CTMUHB.

We generally work well in partnership with Local Authorities to provide a holistic package of support for older people who need to leave hospital. However, we want to strongly convey that the third sector plays an integral role in supporting both Local Authorities and hospitals to discharge patients safely back into the community. Without having the resources of the third sector to fall back on, Local Authorities would struggle to deliver essential works required to safely discharge a patient from hospital.

Care & Repair's service fills the gaps that local authorities and hospital staff cannot deliver. One Hospital to a Healthier Home caseworker based in the Royal Gwent told us: "Hand in hand Hospital to a Healthier Home and Home First work really well together, they have hospital based social workers with their expertise referring to us with our expertise, and I think it's a really good

system." Works frequently referred to us include home adaptations, furniture moving, key safe fitting and home safety checks like gas and electric, and excess cold.

However, there are some instances where system pressures get the better of the system, with several caseworkers articulating the complexity of cases the service can receive, as well as referrals that should go to Occupational Therapy or where social services are involved and refer to us despite knowing that the patient's environment isn't safe to go home in that hope that we will be able to provide solutions. This was articulated in the following ways:

> *"I have one case at the moment where the patient is still in hospital. The social worker asked for a handrail because of access to property. When I got there, there was no pathway to put rail on. The property derelict with no heating hot water, the patient had been showering with a garden hose. It's not fit for him to go back to. Why did the social worker only refer to the rail? They know we will go out and see the bigger picture"*

> *"Some things are not within our remit. Had a referral for patient in and out of hospital, we organised two deep cleans for this lady. The social worker met the Care & Repair handyman to let him in for electrical works for discharge; when we got there was no heating or hot water and obstruction to chair, no fridge freezer – the social worker had been out that morning and deemed okay for the lady to go home. We were able to go out and see client morning after discharge, took her blankets, and have provided heating. Questions about why we are doing it, why wasn't it picked up in the visit?"*

> *"I had a referral to visit a lady last week with complex disabilities, living with her daughter and two grandchildren. Her bed is in same room as granddaughter's bunk beds. She's stuck in bed, extremely cramped. The Local Authority had looked at extension but not enough room. We have been asked to look at it, but realistically what can we do? They can't afford to move. Four of them, three generations in three-bedroom house. This is a social worker's job."*

Increasingly we are seeing older people living with complex issues of disrepair, where a referral for a small adaptation assessment or fitting escalates to intense casework to attempt to make the home safe and suitable for recovery.

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;

Although we cannot speak on behalf of Local Authorities, we know that our service helps speed up safe hospital discharge and fills gaps in service provision that would otherwise lead to delays in discharge. In financial year 2023-24, the service completed over 7,500 home adaptations and

home improvements to a value of over £1.76 million, and saved the Welsh NHS over 24,000 bed days, directly supporting over 4,100 patients to leave hospital more quickly.

In the first six months of 2024-25, the service received 2,718 referrals to facilitate safe hospital discharge for older patients who are clinically optimised but cannot go home due to a housing or environmental issue. **The service reduces a patient's length of stay in hospital by 6 days on average.** Via our Hospital to a Healthier Home service, we have saved the Welsh NHS an additional 11,200 bed days in the first half of this financial year through speedier, safer hospital discharge.

Mindful to be conservative with our cost savings estimates, taking a standard bed day figure at £345[i], the Hospital to a Healthier Home service has saved the Welsh NHS £3.8m in the first six months of this financial year (2024/25) **alone** on bed days saved. This figure doesn't include the staff time and system efficiencies we have saved, or the cost savings associated with preventing readmission. We believe this makes for a strong case for recognising the tangible role the third sector plays within this system to enable safe hospital discharge and improve patient flow.

The main barriers for local authorities in effectively facilitating the discharge of patients with care and support needs, including:

Our Hospital to a Healthier Home service receives referrals to complete adaptations or adaptations assessments from local authority employed social workers regularly. Without Care & Repair, these issues would be a barrier to discharge as the home would not be suitable for the patient to be discharged into. Our service provides fast, practical solutions to issues that would otherwise go unresolved or take much longer to resolve. In particular, this often involves:

- Same day referrals for key safe fittings to allow a carer to access the property once a package of care has been put in place. If not done in a timely manner, this package of care goes to another patient and can result in long delays to discharge for a patient who is otherwise medically fit to go home.
- This is the same for moving furniture. We frequently receive urgent referrals for bed moves to create a safe environment for sleeping downstairs for patients who are being discharged but are less mobile.
- Small bathroom adaptations such as handrails around showers, to enable personal care as part of a package of care.
- Clean and clearance to enable safe movement around the house for both the patient and carer.
- Mobility aids like handrails, grab rails, ramps, stair rails.
- Maintenance issues at properties.

We are able to complete these works because our specialist Hospital to a Healthier Home caseworkers are able to leverage capital for works via our national Rapid Response Adaptation Programme, meaning we can respond to urgent requests for hospital discharge. Nationally our average for all adaptations via this programme is 14 days, but for a Hospital to a Healthier Home referral we can complete works the same day or next day. This demonstrates the importance of having specialist caseworkers bridging the gap between hospital and local authority.

Social care capacity and workforce shortages;

The feedback varied across Wales, however consistently caseworkers referred to challenges for care packages for patients living in rural areas with caseworkers covering a locality with both rural and urban areas particularly commenting on the difference even within the same local authority. Caseworkers from across Wales also noted increased instances of older people being discharged from hospital without a care package in place, with friends and family expected to fill the gaps whilst a care package is sourced.

Waits for care assessments (and other assessment related issues),

We cannot speak on the wait for care home assessments. However, all our H2HH caseworkers are Trusted Assessor qualified for assessment for adaptations. Guidance produced by NHS Exec can be unhelpful because it uses the term Trusted Assessor as a blanket term but can mean different things in different contexts, e.g., other third-sector organisations in the same area might employ staff under an umbrella term of Trusted Assessor but they are assessing very different things. This has put some additional pressure on our services in some areas where referrals are made to Trusted Assessors in other organisations who cannot complete assessments for adaptations – these referrals then come to us but indirectly from the hospital, making it more difficult to liaise with hospital staff around discharge planning and works schedule.

Challenges in arranging care home placements or home care packages, and

Our service is specifically about getting people out of hospital more quickly into their own homes. As mentioned in the paragraphs above, we support the timely provision of care home packages through our home improvements and adaptations, most commonly through key safes and small adaptations. However, sometimes we come across more challenging cases where

more intensive works are required to enable a package of care to go ahead requiring rigorous intervention work with both the patient and their home. Our caseworkers gave the following examples verbatim:

> *I am currently on a case where the gentleman has had an overcrowded property without heating. He has had a stroke and now needs a hospital bed, bariatric commode and steady with downstairs living. He has had repeated failed support from carers as they cannot use equipment safely, so he has sent them away through not allowing things to be moved and thrown. He has now allowed us to undertake a clearance that now allows us to look further into heating issues and allows for ample room for equipment for the care package to go ahead.*
>
> *I had a lady in the past who physically could only access one room of her property, her electrics were faulty and there were leaks all around the property. She couldn't mobilise around the property and she could not have had personal cares given. We did a mass exercise of clearing and giving to a cash for clothes which also aided in funding new white goods, then she could be discharged to receive care at home.*

Disagreements or legislative barriers affecting discharge decisions;

Care & Repair are not involved in this.

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;

We believe H2HH is an example of best practice. The service has operated since 2019 and is currently funded locally by 5 LHBs or RPBs. Until recent months, this service has been funded annually in each health board following a successful Welsh Government pilot and embedding period, although following a tender process in one health board the service will funded for three years from April. However, in other health boards the service remains annually funded, despite a high referral rate, proven cost savings and strong outcomes. Over the years we have worked hard to develop relationships with hospital staff, and each year these relationships are at risk as our specialist H2HH Caseworkers must decide whether to leave and find more reliable employment or wait to see if the funding is renewed. This is particularly insecure given that for some health boards last year the funding wasn't confirmed until March for the financial year starting in April.

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.

We would have liked to see mention of partnership with third sector included in this consultation. As evidenced in this response, our Hospital to a Healthier Home service is highly referred into and well used by hospital and local authority staff. Over time this service has become a trusted go-to for staff looking for solutions to problems. We undertook a three-year evaluation to understand the impact of the service and understand why hospital and local authority staff refer into it and found that staff use the service because it:

Eases hospital pressures by speeding up safe discharge:

"We had a new member of staff recently who moved from England, and she couldn't believe that we had a service that would go out the same day to do a key safe… that's why we add it into the introduction to the team because it's a pathway we use for a lot of our cases." Social Worker in the Joint Discharge Team, Withybush Hospital

"That pressure of flow in the hospital. Any kind of delay in length of stay, it just backs up and clogs up the whole system… by having these adaptations, it's reducing the need on the service, it's keeping people independent in their primary environment." Occupational Therapist Clinical Specialist, Bangor Hospital

Is an embedded and accessible service:

"[The H2HH caseworker] sits on our clinically optimized meetings weekly, and then we discuss any hurdles that there are for patients to go home, which quite often is a lot of the housing issues, whether it's cleaning or rails and so on," Site Matron, Neath Port Talbot Hospital

"[The service is] built into our initial assessment as a pathway onwards, that's how much kind of we use it. And it's actually a part of our team. As I started the role, it was introduced to me as a service that we use for patients to support discharge" Occupational Therapist, Medical Surgical Team Ysbyty Gwynedd

Has reliable communication:

"It's lovely to have those two-way conversations so that we know exactly what's happening. And we can feed back to the board, we've been asked all the questions all the time, you know, when things been done, equipment going in, etc. So I think having [the H2HH caseworker there] there as a point of contact and advice and keeping the momentum is really key," Occupational Therapist, YYF

Operates in partnership:

"One of the best things that we've had really is that [the H2HH caseworker's] visit the home sometimes, and she'll take photos, which has really been helpful for us in the hospital… then we can add that to our assessments here." Occupational Therapist, YYF

"He can look at things that we might not necessarily think of as well, I think he can see it from a different perspective. And think of different ways that we can get things resolved that we wouldn't be able to do. And a good example of that is things to do with cleanliness in properties deep cleans." Band 7 Occupational Therapist, Prince Charles Hospital

"As an OT, we would spend a lot of time trying to facilitate the minor adaptations key safes and trying to find grants and things for cleaning homes, which would remove our presence from the ward for doing rehab assessments ourselves. So if anything, you're allowing us to do our role to a better standard while we're able to just link them with you, just for a small window of our working day, and know that that's going to be sorted in the background and that we are getting those updates as we go along." Occupational Therapist, Ysbyty Eryri

The Hospital to a Healthier Home service is an integral part of enabling safe hospital discharge for older people, improving patient flow in hospitals, and reducing readmissions. Our housing expertise and ability to work in both hospital and community settings means we are able to offer a holistic approach to hospital discharge, considering and solving the needs of both the patient and the property.

For further information on the topics raised in our response, please contact:

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[i] Figure: £345 = Average cost of a standard bed day
Data and Methodology: using cost collection data for 2020/21, the most recently available data, the unit cost per day of NHS hospital beds is as follows: elective - £2,349; non-elective - £901; critical care - £1,881; standard bed - £345.
Ref: Written questions and answers - Written questions, answers and statements - UK Parliament