British Association of Social Work Cymru

Written response to the Local Government and Housing

The role of local authorities in supporting hospital discharge

Foreword

BASW Cymru warmly welcome the opportunity to submit evidence on the role of local authorities in supporting hospital discharges. As the leading professional association for social work and social workers, BASW Cymru have consulted extensively with members to draw upon their front-line experience to ensure the voice of practitioners is heard. In addition, we draw upon research undertaken by BASW: Social work in NHS hospitals: Opportunities and challenges[1].

In 2022-23, there were around 18.3 million admissions to NHS hospitals across the UK, which equates to around 27,105 admissions per 100,000 population. Hospital admission is therefore a relatively common experience, and for many people will be a brief event from which they quickly recover. However, a hospital admission may also arise from an illness or injury with a longer recovery period, or from a long-term illness or disability. For some people, a discharge from hospital becomes an important opportunity to plan and organise the support needed to maintain the individual's wellbeing. Ward staff, other clinical staff, families or the patient themselves may make a referral for adult social care, before, during or after the admission. Only a small proportion of hospital patients will be referred to adult social care, and, other than the overarching principle that referral should be made when a patient's discharge from hospital is likely to be hindered due to significant social care needs that warrant assessment and support[2] from the local authority, there are no standard referral criteria.

Recommendations for Policy and Practice

I. Develop the professional identity of social work in healthcare settings. Social workers across healthcare settings, including acute hospitals, should be able to articulate their value to patients and to organisations, beyond the monetary value of expediating discharges. A focus on care ethics, practice models and methodology underpinned by legislation is essential to support social workers to develop a sense of their value base and the unique perspectives they can bring to bear when an individual is in hospital or ready to leave hospital.

2. Maintain (or reintroduce) a social work presence in acute hospital settings. Even if Discharge to Assess becomes the dominant model of progression from an acute hospital setting, social work skills are vital to ensure that rights and choice are upheld and that there is minimal negative impact on relationships and wellbeing. Social work support continues to be

[1] Social work in NHS hospitals: Opportunities and challenges | BASW

[2] Social Services and Well-being (Wales) Act 2014 provides the legal framework for eligibility and assessment criteria

most important at the point of considering long-term plans following a hospital admission, however decisions made in the short-term have an impact on the options available later, and so short-term decisions should not be regarded as trivial.

3. Promote the value of social work skills in the hospital setting such as therapeutic support to individuals and families facing change, social work specific practice models and methodology, safeguarding adults at risk of harm; and supporting the education of clinical colleagues, to reinforce a holistic approach from the health system.

4. Develop robust systems for appropriate information-sharing, that protect patient confidentiality but minimise the burden of seeking information about a patients' health or social care needs. This might be done by way of reciprocal read-only access to hospital and social service note-taking systems.

5. Ensure that Discharge to Assess models are sufficiently resourced to give meaningful opportunity for rehabilitation, recuperation and long-term assessment. Models based on residential care must maximise independence in a meaningful and risk-positive way and not miss out essential life-skills such as access to cooking facilities, medications, or travel in the wider community.

6. Named Social Worker for every patient. The inquiry should look to investigate the potential to develop 'named social worker' protocols for people with discharge needs. This will reduce bureaucracy, ensure continuity of care and person centered care and remove the sense of 'throughput' through the system.

7. Protected workspace within the hospital for social work staff. Hospital social workers are not always based in the hospital they support, yet data suggests that some social work staff are working in unsatisfactory conditions within the hospital, which limits their access to patients and family to gather the information they need, and also their ability to form good working relationships with clinical colleagues.

Understanding the hospital social work role

One of the key roles for social workers in acute NHS hospitals is to assess the needs of individuals and to organise social care support for after discharge from hospital. This can range from arranging relatively simple practical support (such as providing information about services), through negotiating different funding streams from health and social care budgets, to supporting complex assessments of risk and of mental capacity. Social workers contribute by bringing knowledge of resources outside of the hospital, as well as specialist knowledge around key legislation, particularly mental capacity legislation.

Social workers often take a position outside of the professional hierarchy of the NHS, and this can have advantages when it comes to providing an independent point of view from that of clinical colleagues. This ability (and professional responsibility) to challenge may be enhanced by the usual position of a social worker employed by the local authority rather than directly by the NHS. Different stakeholders in the discharge plans often have different opinions of what is and is not acceptable risk. However, a consistent finding within the research[3] [4] [5] has been the importance of social workers in advocating for patients and families in the hospital setting, centering discussion on the patient's wishes. Alongside assessment, discharge planning, and advocacy, hospital social workers may also be involved in a range of other professional activities, such as safeguarding adults, education (for both colleagues and patients) and therapeutic support to patients and carers.

Views of hospital social work

Social workers often report feeling like social work falls outside of the core work of an acute hospital, and as such it can be difficult to be accepted by the hospital administration or by clinical colleagues. In contrast, clinical staff often appear to highly value the support that social workers give to their patients, citing their ability to advocate for the patient and to navigate complex social care systems outside of the hospital, although in our research[6] clinical staff did mention that social work input can also feel like a disruption to the smooth running of a ward. Evidence about patient and family views of hospital social work is more limited. However, social workers are recognised by patients with helping to identify and mitigate barriers to a safe discharge home and giving more time to emotional wellbeing than other professionals may be able to.

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[3] Burrows, D. (2020) Critical Hospital Social Work Practice. London: Routledge
[4] Burrows, D. (2022) 'Social work for 'liquid old age': Some insights from an ethnographic study of a hospital social work team', Ethics and Social Welfare, 16(3): 258-273
[5] Heenan, D. (2023) 'Hospital social work and discharge planning for older people: Challenges of working in a clinical setting', Ageing and Society, 43(6): 1333- 1350
[6] Power, L., Dean, L., Evans, L., Haughton, A. & Holmström, C. (2023) 'Mystery and magic: Perceptions of social work within an acute hospital setting', Practice (Social Work in Action), 35(5): 405-423

The health and social care system rely heavily on one another to work smoothly; however, the last 20 years have seen rhetoric about the failures of social care impacting on the NHS, and a focus on the financial cost of 'delayed' discharges from hospital, rather than the quality of the support given when a patient leaves hospital.

One member commented that too much focus is on throughput at the expense of limited research/understanding of the longer-term impact of not enabling people to stay longer in hospital. Whilst there is data available around health deterioration if stays are prolonged, there is limited data available on how social and emotional factors are improved through longer stays and improved assessments linked to time to undertake and implement a care plan.

Discharge to Assess models have been developed to tackle the financial and health costs of longer hospital admissions, by discharging patients as soon as possible. Discharge to Assess is a model of discharge planning that situates longer-term assessment and decision-making outside of the hospital, rather than discharge plans being made while the patient is still in hospital. This might mean a transfer directly from hospital to home, or to a residential step-down service where additional assessment and rehabilitation is offered, rather than a longer hospital stay. Initial findings from our research[7] into the effectiveness and acceptability of Discharge to Assess models suggest that they can have a positive impact by freeing up acute hospital beds, and that patients often prefer to recover in a less clinical setting or at home. However, inconsistencies in resourcing and integration of health and social care can undermine this impact by failing to provide the follow-on support that is required.

One member reported that Discharge to Assess was utilised as a quantitative measure for discharge, largely financial and the focus on 'organisational throughput' of patients reduced opportunities to assess the qualitative aspects of care required to ensure positive wellbeing and full recovery.

Another member highlighted a local pilot recently started in Ceredigion called, 'Discharge with Confidence[8]', a free (Welsh Government short-term funded), limited support service for up to a maximum of 2 weeks. This service focussed on alleviating some of the anxiety surrounding hospital discharge for those who may not have support waiting for them at home. Following referral, the coordinator would link the individual to a 'micro-enterprise', who would support them for up to 2 weeks and cover things like meeting them when they arrived home, making sure the heating is on, getting the shopping in, light cleaning, transport as well as support to seek advice and assistance through the local centre for independent living.

A recent challenge to both the NHS and social care has been the Covid-19 pandemic. At the height of infections, political and media focus in the UK was on 'saving the NHS', while social care and other vital services were not recognised in the same way. Government policy was

[7] Offord, N., Harriman, P. & Downes, T. (2017) 'Discharge to assess: Transforming the discharge process for frail older people', Future Healthcare Journal, 4(1): 30-32

[8] Discharge with Confidence, Ceredigion County Council. Email lis.cooper@ceredigion.gov.uk

updated frequently and communication between health and social care services was not always clear. Many social care staff, including social workers, were concerned not only about their own health, but also about the wellbeing of the people they were supporting. Use of Discharge to Assess models was accelerated and both the NHS and local authorities are now directed that Discharge to Assess should be the norm when an adult is well enough to leave hospital. BASW Cymru members report that following the Covid-19 pandemic, there has been a reduction in social workers positioned within hospitals which is significantly affecting their ability to undertake their role fully, to work in an integrated way and to ensure focus is consistently on the rights and needs of the person and their families/carers. Throughput has become the order of the day with little time given to ensuring continuity of wellbeing for the person and acknowledgement that there are real risks to preventing sufficient time for recovery and rehabilitation.

As one member commented:

'No one ever says, thank you for getting my loved one out of hospital so quickly'

The structure of hospital social work teams

As with elsewhere in the UK, hospital social work teams are more likely to be employed by the local authority than by the NHS in Wales, where there are 22 local authorities, 7 local health boards, 3 NHS Trusts and 2 special health authorities. There is limited information available to determine exactly how many dedicated hospital social work teams there are currently in Wales, and how they are configurated in terms of the ratio of qualified and non-social work qualified staff employed within them. However, in their 2023 Social Care Workforce Report, Social Care Wales presented data covering all social work teams in Wales, indicating a ratio of approximately 47% are social work qualified with around 34% being non-social work qualified. Non-social work qualified roles are occupied by staff who are typically very knowledgeable, experienced and skilled, however they do not hold the standard minimum qualification to register as a social worker; and they are paid less than qualified social work colleagues. The job titles for these roles vary greatly within and between local authorities and practice settings in Wales. To illustrate, a quick poll of 7 local authorities in Wales undertaken by BASW Cymru found the following: Adult services – Assessor care coordinator/manager, support worker, social care assistant. Children's services – childcare practitioners, childcare/child protection support assistants. This suggests that the non-social work qualified role is diverse and used in a variety of ways to support proportional assessment within social work teams.

It is generally understood that non-social work qualified roles do not carry the same level of statutory powers, duties and responsibilities as qualified social workers with respect to safeguarding and assessing risk. However, quantitative data from our surveys indicates non-social work qualified staff are not only engaged with assessments of eligibility for social care support, but also involved in complex or high-risk decision-making processes, such as assessing mental capacity, best interests and other safeguarding issues.

Ensure protected workspace for social work staff within the hospital.

Hospital social workers are not always based in the hospital they support. According to freedom of information replies within our research, at least 88% of local authority and 78% of NHS hospital social workers have access to office space within the hospital or other NHS property. However, annotations to freedom of information replies, as well as interviews and survey responses, gave a more complex picture: e.g. hot-desking on a shelf in a hospital corridor.

Agile working is common, and a small number of participants described this as a positive factor allowing them to achieve a good work-life balance. However, finding space to work has significant limits on their ability to form good working relationships with clinical colleagues, and most importantly to spend time building rapport and gathering the information they needed from patients and families. Information sharing is vital when it comes to making good decisions about discharge and post-discharge care, but participants felt that gaining relevant information had become more difficult. In a time where the NHS is under pressure and ward staff are under pressure to discharge patients it is becoming increasingly difficult to ensure that information given is accurate to inform assessments and to ensure the best outcome for patients. Proximity to colleagues from different professions or different agencies can make a positive difference to multi-disciplinary working, allowing information to be shared more openly and more quickly, and physical distance can have the opposite effect. Frequent changes of staffing, such as when social workers are not allocated to work with a specific ward, can also negatively impact these working relationships by reducing familiarity between staff from different disciplines. It is therefore concerning that social workers have limited access to the hospitals they support.

Social work practice in hospital settings

Bridging gaps between health and social care, or between hospital and community have emerged as key identifiers of good hospital social work. Social workers spoke about acting as advocates for patients and families and about deploying knowledge about both the patient and their social setting to make robust discharge plans.

'No disrespect to therapists and health colleagues, but sometimes they're a bit blinkered, can't always see outside of a box with someone. You know, they see what the problem is, not what support could be in the community for that, rather than straight into a 24-hour care placement'

Social worker focus is on the people they support and facilitating individual choice and relationships as key factors in decision-making:

'[The daughter] was a trained carer, she was really sensible, she was really lovely, she doted on her mam so much, and she wanted to take her home… the ward staff just wanted me to just put her mam in a care home and I was like 'I don't think that's right, I think this daughter can really look after her mam'.

Through the consultation, our members spoke about prioritising the emotional consequences of the decisions they make and often felt that clinical colleagues prioritised physical wellbeing and risk over emotional wellbeing with limited awareness of the interplay between both states. Some also spoke about social workers having a role in understanding the patients' past and envisioning their possible future in a way that clinical staff do not have time to do. While members could see the need for movement and through-put to free up space for future patients, social workers tended to prioritise the needs of the person in front of them.

A key role for social work in hospital discharge, is bridging gap with external care providers to secure packages of care. This requires excellent knowledge of a complex care system, enhanced communication skills and the ability to empower and facilitate changes for both providers and the person requiring care. Our members reported that they are consistently in positions where they are unable to secure the care required with the key reason being low pay of care workers combined with the negative image that surrounds care work. Our members noted that negative portrayals of care work combined with low pay and poor working conditions, are the key drivers in difficulties in securing appropriate care which is person centred. They reported that some care agencies are no longer recruiting and are now only delivering care and support within current resources and defined geographies. Whilst most social work assessments are undertaken in a timely manner, these difficulties result in significant delays which often leave social workers feeling accountable to the person and family. In addition, our members reported that there are specific needs which are becoming increasingly difficult to secure support: people at risk of falling, people who may have associated aggressive behaviour. Thus, those is highest levels of need are perceived as more complex and may have longer waits for care and support packages to be in place. One member commented that;

'Care homes insist on reassessing their existing residents before accepting them back after a hospital stay and often delay this assessment citing various reasons often related to their own staffing levels. Local authorities are reluctant to agree funding for enhanced packages of care and have internal decision-making panels that often delay discharges'.

This can result in substantial delays where decision making is not situated close to the person and with the named key worker. In addition, different discharge processes (e.g. Continuing Health Care (CHC), Best Interests Assessment) require different assessment protocols, which may also result in lengthy disputes, eligibility issues and rising costs, adding further delays and layers of bureaucracy.

In some instances, members reported that when these factors are combined, they can lead to unsafe discharges where bureaucracy and systems prohibit the voice of the person and their family being central to all decision making. Focus on the measurement of throughput, does not allow for individual's voice to be central. As one member commented:

'When people don't feel listened to, they feel hopeless. And when we get hopeless, then we get very poorly. Hope is about listening, and when we feel listened to, I feel valued and heard'.

In common with previous research, social workers also talked about their specialist legal knowledge, particularly around mental capacity. They often felt that clinical colleagues did not have enough understanding of mental capacity legislation and felt that it was their role to provide checks and balances against broad assumptions being made about patients' capacity to make decisions

'Clinical colleagues will say 'they don't have capacity' and you have to say 'capacity around what?' and we basically educate medical teams on what the [Mental] Capacity Act is, what it stands for, the legislation and we don't understand how that's still happening. Because it's been in since 2005, so how is that still happening now?'

In addition, our members raised some serious considerations in relation to hospital practices which have a clear legislative base. For example, DNAR (Do Not Attempt Resuscitation) orders are one of the most sensitive aspects of patient care. They require clear documentation, family discussions, and multidisciplinary input. The challenge is not just ensuring the form is completed but navigating the emotional and ethical dilemmas central to DNAR orders. Families often struggle with accepting DNAR decisions, particularly when they feel they are "giving up" on their loved one. DNAR orders should never be a standalone decision made purely by doctors. There is a critical need for holistic, person-centered discussions that involve palliative care specialists, social workers, mental health professionals, and the patient where possible. This ensures that the decision reflects the patient's values, beliefs, and quality of life considerations, rather than being a purely clinical judgment.

Advance Planning: The Need for Proactive Conversations. Advance planning is essential, yet it is often ignored or left too late. This leads to crisis decision-making, where patients and families are forced to make high-stakes choices under emotional distress. Advance planning should include:

• Early discussions about DNAR and end-of-life wishes when a patient is diagnosed with a progressive illness.

• Legal documentation, including Advance Directives and Lasting Power of Attorney (LPA), to ensure patient autonomy.

• Psychosocial support to help families navigate grief and decision-making.

Our members report that they have experienced many families left unprepared for sudden health declines. Without advance planning, conflict often arises, some family members may push for aggressive treatment, while others advocate for comfort care. This could be avoided if integrative planning was initiated earlier, ensuring the patient's voice remains central even when they can no longer communicate.

Integrative Practice should be an ideal and day to day working practice within the hospital discharge process. Hospital settings can be fragmented, with different professionals focusing on their specific domains, doctors on medical treatment, social workers on discharge planning, and therapists on rehabilitation. However, without integrative practice, patients and families often fall through the silos, receiving disjointed or contradictory information. Social workers, our members want to work in an integrated way, adopting integrative practice models which are based on:

• Interdisciplinary communication – ensuring doctors, nurses, social workers, and allied health professionals are aligned in their approach.

• Collaborative decision-making – particularly in cases of DNAR, palliative care, and end-of-life decisions.

• Holistic patient care – recognising that medical interventions alone do not define well-being; emotional, psychological, and spiritual needs are equally vital.

When integrative practice is absent, patients and families suffer confusion and distress, and professionals work in silos rather than as a cohesive team. An integrative care model enables trust and communication to be built and shared, cornerstones of professionals working together. Members report that the best patient outcomes occur when professionals actively share knowledge, perspectives, and resources rather than treating their roles as isolated tasks. It also assists in avoiding the over prescription of care which was frequently cited by BASW Cymru members.

Hospital stays have reinforced the critical importance of DNAR clarity, integrative practice, and advance planning. Healthcare should not be reactive but proactive, holistic, and collaborative. DNAR decisions should be made with compassion, integrative practice should be standard rather than optional, and advance planning should be normalised rather than feared. Ultimately, the goal is to respect patient autonomy, provide dignity in care, and reduce unnecessary distress for families and professionals alike.

A member reflected on their personal experience of supporting an older relative during hospital discharge where the assessment was carried out in English, which was not her first language Welsh, and also by a male Occupational Therapist. Due to the barriers with language, and in discussing personal matters with a male, the assessment was 'completely wrong'. Following a request for a re-assessment, a Welsh-speaking, female worker conducted the assessment, which was far more effective and resulted in a successful transition from hospital for the individual involved. This illustrates the importance of individuals being given the opportunity to be assessed in their chosen language and by the right person.

The changing nature of hospital discharge

There are indications that social work is being moved out of acute hospital settings. Within the BASW Uk research[9] explanatory notes appended to freedom of information responses indicted that Covid-19 restrictions were partially responsible for this change.

'When Covid restrictions came to force, the [NHS] asked the local authorities to move the social work staff out of the hospital. The staff have been relocated to strengthen the community social work teams and there is no intention to reintroduce the roles'.

Evidence suggests that where hospital social work teams have been withdrawn from hospitals, if they remain as a team, they are more likely to keep their identity and main role as the 'hospital social work team'.
Some members who work on Discharge to Assess models, described the system as complex. One team described options for rehabilitation, short stay residential care, and settings described as more of a convalescent home, to recover from illness or injury but not necessarily to receive therapeutic input. All these options incurred different costs and might be self-funded by the patient or eligible for financial support from the NHS or local authority. The research[10] found that respondents were unsure about the value of Discharge to Assess models, with many respondents reporting that patients could be moved into residential care without proper consultation with the patient, family, or the local authority most likely to be responsible for the patient's ongoing care and support. Some participants could see the value of completing longer term assessments outside of the hospital setting, but none were unequivocally positive about the idea

Evaluations of Discharge to Assess models suggests that a lack of funding of community-based services for patients to access once they are discharged is one of the main barriers to effective implementation. There is also a risk that implementing Discharge to Assess models will simply move the problems of hospital discharge to a different setting. If community-based services and residential rehabilitation do not have the capacity to meet demand, and to provide holistic rehabilitation, then the health and social care system is likely to continue to experience delays, blockages and increased demand

Acknowledgements

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[9] Social work in NHS hospitals: Opportunities and challenges | BASW
[10] Jeffery, S., Monkhouse, J., Bertini, L., Walker, S. & Sharp, R. (2023) 'Discharge to Assess: an evaluation of three case studies in the southeast of England to inform service improvement', BMJ Open Quality, 12: e002515