MEETING	Care Scrutiny Committee
DATE	25 September 2025
TITLE	Hospital Discharges Project
REASON TO SCRUTINISE	Council Plan 2023-28 - A Caring Gwynedd
AUTHOR	Sian Edith Williams Jones Lynne Lloyd Jones Manon Elwyn Owens Rhian Green
CABINET MEMBER	Dilwyn Morgan

CONTENTS OF THE REPORT:

1. Why is there a need to scrutinise Hospital Discharges?

1.1 Collaboration with the health service is one of the Caring Gwynedd priorities and one of the work streams is to work with them to ensure that care is available to patients discharged from hospital.

1.2 A report was recently published by the Welsh Government on this, as well as a report from the Heads of Social Services responding to the challenges relating to care following being discharged from hospital.

1.3 The Council is also required to create a plan detailing the care path of those who are discharged from hospital, and it is a requirement that we report annually on progress to the Welsh Government.

1.4 Therefore, it is appropriate for us to scrutinise this field of work and what is happening in response to the challenges that arise.

2. What exactly needs scrutiny?

2.1 Scrutinise the report from the Wales Heads of Social Services to understand the context and the challenges.

2.2 Consider possible solutions in Gwynedd including the necessary investment.

2.3 What is the link with Cyngor Gwynedd's Llechen Lân plan.

2.4 Data about the number of patients who are awaiting discharge from hospital and awaiting a domiciliary care package.

2.5 Data about the number of patients who are awaiting a community care package and does providing a care plan to those who are ready to be discharged from hospital affect those who are waiting for a community care package.

2.6 Data about the number of patients who have been refused for a care package and why.

2.7 Forward scrutiny of the care path and progress.

3. Summary of the Key Matters

3.1 In the report we set out the current context on the hospital discharge arrangements in Gwynedd by the Community Resources Teams who support adults with physical needs, sickness, conditions associated with old age and dementia. There will be an emphasis on the principles of the Social Services and Well-being Act and the expectation for us to be considering individuals' personal resources and strengths when assessing and planning care and support needs when a person is discharged from hospital.

3.2 We will ask the Scrutiny Committee to consider the efficiency of our current arrangements in terms of providing local support, that is commensurate, timely and safe for Gwynedd residents within our current resources. Answers to the above scrutiny questions will be included in the relevant sections of the report.

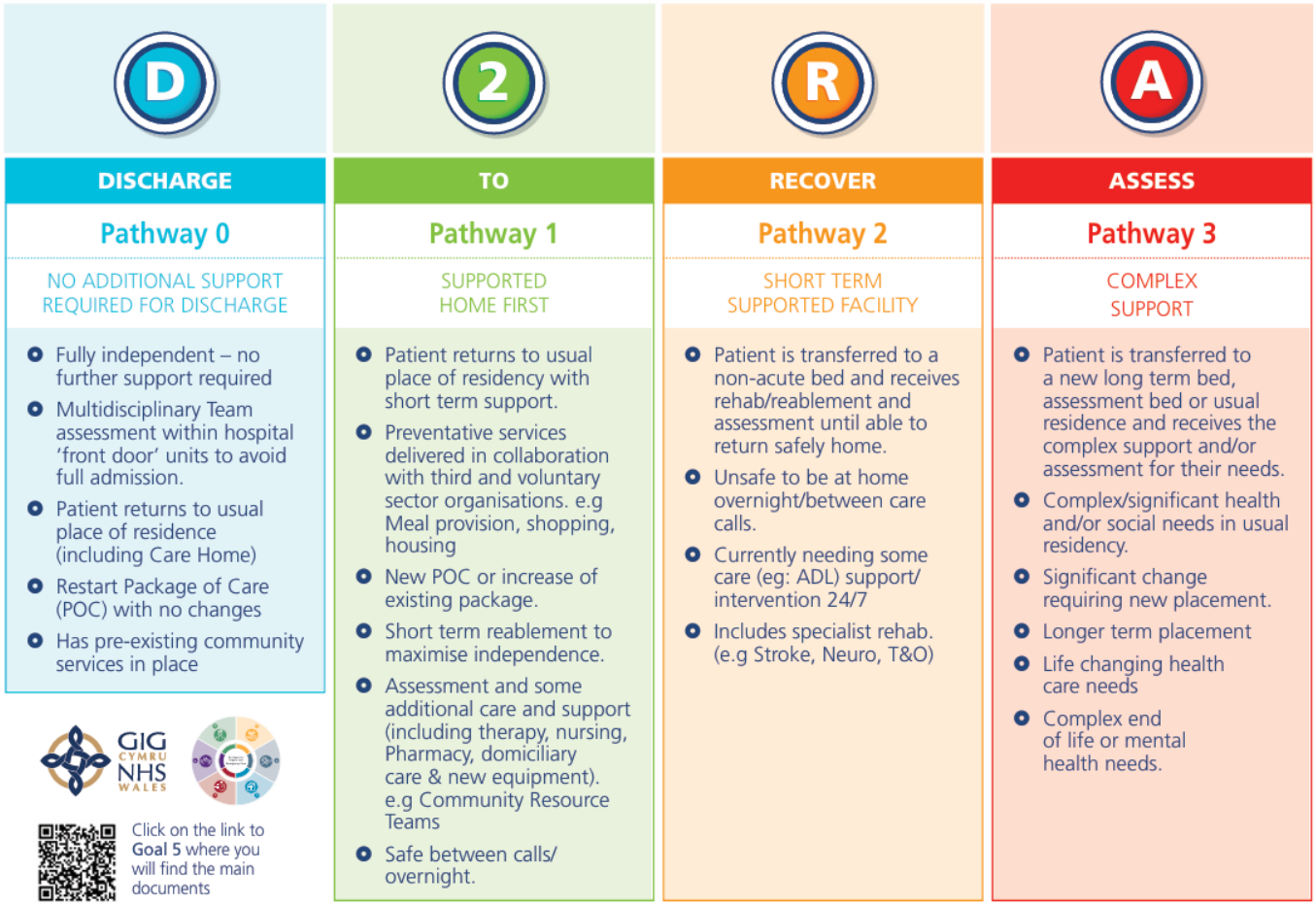
4. Background / Context

<u>The legislative and practical context</u>

4.1 The Social Services and Well-being (Wales) Act 2014 is the legal framework to identify a person's personal outcomes and to assess their care and support needs. Social Services have a duty to meet the need if the resources (personally, in the community or by others) are not available for the person to meet their own needs.

4.2. The NHS in Wales uses specific codes to specify the pathway of persons who need to be discharged from hospital. They are based on the principles of Discharge to Recover and then Assess (D2RA).

4.3 There are four streams, namely, 0, 1, 2 and 3. See the diagram below that explains the purpose and principles of these pathways.



4.4 The various features that belong to each stream require a specific treatment. Therefore, it was decided to commence the work of revising our arrangements in the Council with pathways 0 and 1.

4.5 Work is underway to improve our cooperation and our arrangements with pathways 2 and 3, however, as this is just starting, it would not be appropriate to include these in this report.

4.6 Please note also that health boards and local authorities have operational language and terminology that are unique to them. The concept of D2RA is an example of that. So, as part of the collaboration, we're also working on improving understanding of each other's vocabulary and procedures.

4.7 StatsWales data, which is published monthly under the guidance of the Welsh Government, identifies and codes the reasons for delay prior to patient hospital discharge. They are initially specified by the team responsible for hospital discharge in the Health Boards and are checked and approved by leaders in the relevant Social Services.

4.8 Below is a table summarising and highlighting the averages that are relevant to the work and this report.

Table 1: A summary of StatsWales statistics showcasing the number of medically fit individuals awaiting hospital discharge (relevant information for this report is highlighted in yellow).

			Average of each calculation since 2023	Jan-Jul 2025	Jan-Jul 2024	Difference	Jan-Jul 2025 %	Jan-Jul 2024 %
Total	All delay categories		62	57	58	1		
Total	Assessment and GC		29	27	28	1	48	48
Total	Assessment		20	20	18	-1	35	32
		Awaiting a social worker.	4	4	5	0	7	8
		Awaiting a social services assessment	4	4	4	0	7	7
		Awaiting a joint assessment	8	6	7	1	10	13
Total	GC Issues		9	7	9	2	13	16
		Awaiting a new care package	9	7	9	2	13	16
		Awaiting a care package to recommence	2	-	1	1	0	2

4.9 Specifying a social worker and an assessment from a social worker are two reasons that contribute to the delay. These are two fields that are within our ability to influence and improve and are therefore fields that we address in this work programme and, therefore, in this report.

4.10 See the appendix for more detailed explanation and context to this monthly report and its contents.

The Current Situation

4.11 Since 2011, the population aged over 65 grew by 7.8% in Gwynedd. Social Care Wales reports that Wales has more people over 85 years old than the rest of the United Kingdom and by 2045 the number is likely to double across Wales.

4.12 Furthermore, the Welsh NHS Confederation explains that Wales has the highest number of people with restrictive or chronic long-term conditions in the United Kingdom, with numbers increasing rapidly (from 105,000 people with restrictive or chronic long-term conditions in Wales in 2001/2 to 142,000 in 2010/11) and likely to continue to increase as the population ages further.

4.13 By the 2021 Census, there were more than 25,000 people over the age of 65 in Gwynedd, with around a third over the age of 80. Compared to Wales, there are 23.5% of people over the age of 65 in Gwynedd and 21.3% in Wales.

4.14 This increase obviously brings its challenges, with a high likelihood that there will be more demand for health and social care services. Medical advances have improved

people's survival but have also led to more complex needs. Linked to the ageing population, an increase in the number of people living with dementia and the condition can lead to many complications in terms of care and support which for some affect hospital discharge arrangements, particularly individuals who are unable to meet their own needs and make decisions about their care, where best welfare decisions and the involvement of the Court of Protection are required to organise their continuing care. These are intensive processes with a legal framework and therefore take more time to organise.

Hospital Discharge Work

4.15 By now it is a very common theme that social services are responsible for the delay in an individual's discharge arrangements from hospital. There are actually a range of other factors that extend beyond social care. Delays can be due to an individual waiting for a nursing assessment, a Continuing Healthcare assessment, a delay in completing medical, mental health assessments and the time taken to complete medication arrangements.

4.16 It is a matter of concern that “10 days in hospital lead to the equivalent of 10 years of ageing in the muscles of people over 80 years old." This damage and the loss of independence means that older and vulnerable people are more likely to need care and support to return home, increasing the pressure on social care and community services that are already under pressure.

4.17 The hospital has a method of determining when an individual reaches "clinically fit" status (Clinically Optimised) and this does not necessarily mean that the individual is healthy or has recovered. This status imposes a tight timetable and considers that anyone who is still in hospital 48 hours later receives a "delayed" status.

4.18 Meeting a social worker, trying to agree on a plan for care needs, discussing with the family during visiting time and getting the views of the multidisciplinary team is a complex and difficult time for people. Doing this while the individual is still sick is much harder. People are expected to work through an assessment, agree a care plan or residential placement (which can cost up to £2,000 a week) and all of this to be in place within 48 hours is completely unreasonable and immediately puts us in a position of failure.

4.19 Hospital admission is a significant event in every person's life and deserves adequate attention and investment to ensure that the experience of leaving hospital and engaging with health and social care services is a positive and seamless experience and gives the best start to the journey of receiving any form of care and support. For most, this is when a person receives contact with social services for the first time and this is when expectations are set.

4.20 To date, Gwynedd has received short-term grants to meet the growing demand from the hospital, which hampers our ability to invest in long-term plans to meet an ongoing and increasingly worrying situation.

4.21 The messages and the expectations from various Welsh Government papers clearly state that local authorities must ensure every effort to support people to be discharged

from hospital as soon as possible, and this with minimal additional resources. This expectation comes at a significant cost, impacting our ability to provide wider support in the community.

4.22 With resources and staffing being redirected to prioritise hospital discharge, services such as preventative care, early intervention and long-term support to vulnerable persons have faced increasing stress.

4.23 Although, we all recognise that discharge from hospital is a priority, social care must also be able to provide preventative and continuous support. Without this balance, the pressure on hospitals may reduce in the short term, but the demand for emergency interventions could increase, making the system less sustainable over time. We have therefore had to be creative and balanced in transforming the service and introducing improvements and changes within our existing resources.

Changing culture and the narrative across Health and Care

4.24 We started by communicating the Council's position and the care context with the staff of Ysbyty Gwynedd wards. Recent discussion sessions have been organised emphasising the need for nurses to be sharing accurate messages with patients and their families, preventing over-provision and over-reliance on domiciliary care, asking them to avoid raising the hopes of families and setting high expectations for the care provision, to be comfortable with risk, choice and the decision of patients and to encourage independence if appropriate and safe. This is a challenge and is a conversation that needs to happen regularly.

4.25 When someone contacts the Adults Services, we ensure that a collaborative conversation takes place between the nurse and patient, the family and friends (or any other relevant professional) to gather the required information. This will allow the team to focus on the patient's strengths and resources to support them with what matters to them.

4.26 We must also look at practices and culture in our Social Services Teams when considering providing care and support. There is an effort for us to be moving away from 'traditional' practices. It can be argued that a domiciliary care package can be 'uniform' and rigid and what is the point of carrying out a comprehensive assessment and providing the same type of service to all?

4.27 We need to encourage and support workers to think creatively and to be enterprising and confident with new ideas, which is a huge change for the teams. Historically, there has been an adequate supply of domiciliary care that may have led to over-reliance, hampering the enterprise and creativity of the workforce.

4.28 We now encourage our workers to assess individuals based on their strengths rather than focusing on issues and risks. It is key that employees have the skills and confidence to have good and constructive conversations with the person and the family – needs must be met in a commensurate way to prevent over-reliance and over-delivery of care from the first step, addressing what matters to individuals rather than focusing on providing a total number of hours and specific tasks.

4.29 We promote the use of Direct Payments and the development of the workforce's awareness of local micro enterprises, third sector agencies and the use of assistive technology. Through Direct Payments we can better meet the needs and provide substantial packages at a reduced price.

4.30 There is also an effort to encourage close cooperation with our domiciliary care providers, so that they are key members of the Community Resources Team. This is done by ensuring that discussion forums are in place regularly and consistently and co-locating offices where possible, encouraging and welcoming the views and expertise of carers about the person being looked after, as they are the ones who know the person best. With this we get a provision that is flexible and commensurate to the person's actual needs.

4.31 By now, we have four Social Worker Practitioners and four Community Resources Teams (CRTs) (Bangor, Llŷn, Eifionydd and Caernarfon) located in Ysbyty Gwynedd for 1-2 days a week, they share an office with the BCUHB Hospital Discharges Team. The practitioners work under the new CRT structure which has been split into smaller sub-areas or patches.

4.32 This means that practitioners have a better structure and more local awareness and therefore a better opportunity of identifying the alternative, community, third sector resources, and to look beyond statutory resources. Having a separate and dedicated Team for the hospital would lose the local awareness and knowledge that is now so necessary.

4.33 As a result of recent talks with the Health Board we have an agreement that they will adapt their patient data systems to correspond to Gwynedd sub-areas/patches. This has been done and there are very broad and positive implications in terms of saving time and identifying patients who need to be prioritised.

4.34 As the hospital tends to refer a patient within 48 hours of admission and this without sufficient information about the person and their circumstances, the practitioners on site can check each referral, get access to the hospital's information systems, discuss with the Discharge Team following 'board rounds' and identify the individuals who are genuinely ready for a 'What Matters' conversation (care and support assessment).

4.35 Another advantage of having CRT members at the hospital rather than a separate Team is the transition between CRT and the hospital. This is key and works much more effectively. Because they belong to the CRT, they bring their knowledge of local resources and networks directly to the hospital assessment, where previously it was the hospital that decided the level of care (and gave 'a safe bet' of four calls a day) without the awareness of local services and support in the community in which the patient lives.

4.36 With the four linked to the CRT they can follow cases through from the hospital to the community. The hope is that persons will leave hospital promptly, are less likely to deteriorate and therefore the care needs will be less or more commensurate to needs, which avoids over provision and creating dependence too early.

<u>Scrutiny of data and informatics</u>

4.37 As part of the work, it is important for us to consider quantitative and qualitative (data) as they have their own merits.

4.38 The quantitative data comes from StatsWales, our own databases (mainly WCCIS), and from the information collected by the practitioners during the project. To balance this, patients' stories are collected to understand the situation from the patient and the workforce's perspective, and this gives substance to the more abstract figures.

4.39 We initially look at the quantitative data collected during the plan, and this is compared with the StatsWales data involving Hospital Discharges.

4.40 The practitioners recorded their visits in the form of a simple database, with the aim of identifying what type of impact the intervention had.

4.41 Approximately 100 individuals were seen by the practitioners over the pilot period. Some were recorded in greater detail than others.

4.42 The following table gives information about seven patients from the Bangor area; namely, Bangor City, Bethesda, Penrhosgarnedd, Y Felinheli.

Tabl3 2: Figures showcasing length of stay and patient referrals seen by Social Work Practitioners in the Bangor area (namely Bangor City, Bethesda, Penrhosgarnedd, Y Felinheli) during the pilot.

Clinically Optimised on referral?	Length of stay	Days before referral	Days between Social Services referral and assessment	Days between referral and discharge	Days between assessment and discharge	Path way	Outcome
No	41	21	4	20	16	0	Refusal of support
Yes	24	11	0	13	13	1	Enablement
Yes	25	1	6	24	18	0	Family and equipment
Yes	9	5	2	4	2	0	Equipment and adaptations
Yes	5	3	2	2	0	1	TA
No	22	16	0	6	6	0	Family and physiotherapy and equipment
Yes	27	6	0	21	21	1	TA
	22	9	2	13	11		
		41%	9%	59%	50%		

4.43 In the Bangor area, there was one social work practitioner visiting Ysbyty Gwynedd once or twice a week. The person would receive referrals through the IAA service, from the 'Progress Chasers', through the Board Round on the ward, and when chatting with individual patients.

4.44 We have identified the various referral methods, but to be concise, we will not elaborate on this here. Instead, we wish to focus on the information in the table.

4.45 The table includes seven individuals who were on pathways 0 and 1, which are the most basic support pathways.

4.46 It is shown that the average length of a stay is 22 days. Of these, nine days deal with improving a patient's health to be clinically optimised. Of the seven samples, only two were referred to as clinically optimised. This is significant as early and timely planning for the discharge of individuals from hospital is an important issue.

4.47 If we look once more at the average figures, we see that there is a two-day delay between referral to the social services in Bangor and receiving an assessment, this is equivalent to 9% of all the persons' hospital stay. The greatest delay then occurs after receiving the social work assessment.

4.48 If we compare the above data with the StatsWales statistics where 14% of a person's stay in hospital involves waiting for a social worker and assessment.[1]

4.49 It is very superficial, therefore the quantitative data suggests that the intervention in Bangor assists the social services teams to ensure that their duties are carried out sooner for the patient's benefit. And we're looking for further improvements.

4.50 Only seven months have passed since commencing this work, and we already see evidence of improving the experiences of individuals when discharged from hospital, the relationships created improvement in communication and the Health and Care employees have facilitated access to each other's information systems.

4.51 Below, positive stories are shared from the three areas about persons and how this work has been of benefit to them with their journey through the system - reiterating the message of the above quantitative data in each of the pilot areas.

Case 1

A referral from the ward enquiring about a care package to return home. After my conversation with the gentleman, it became clear that this was not what he needed. Instead of arranging a care package, I arranged a Telecare and 'Falls Detector' system for him as well as a 'Swivel Bather' which allows him to shower and wash his feet independently. He returned home the following day. The family also has peace of mind knowing that the case will be followed-up in the community by me.

I predict that without the What Matters conversation and things like Telecare he would have been in hospital for weeks waiting for an unneeded care package. I also predict that if he hadn't fallen and gone to hospital at that time, he could have been in a more serious situation in the future.

Case 2

A referral from the ward assuming that a gentleman needed a care package before being discharged home, after I went to see him and had a conversation with him, he definitely did not need a care package, he went home the same day.

[1]For information on StatsWales: figures are presented to the Government by Health Boards across Wales on the third Wednesday of the month. A snapshot of the number of persons in a delayed position of discharge from hospital on that day (day of calculation) is given. There is a specific code for the different reasons and the information is checked with the leaders of the Social Services before sending them for analysis. It should also be noted that the StatsWales information looks at the whole of Gwynedd, and we are look at Gwynedd as a whole, at an area level and at a sub-area level.

Case 3

The ward had stated that a lady needed a care package before being discharged from hospital, had an initial conversation with her, shared that she was living with her son and was completely independent at home, I asked the son to have a meeting with me and the mother the following week, he also confirmed that his mother was independent. I understood that she enjoyed cooking and baking, and that this was an important part of maintaining an independent life. Therefore, I said that I would help her go home at once as long as she baked me a cake when I came to see her after she got home. The lady went home with a Telecare system. When I went to see her at her home a week later, she had settled down well and had baked me a cake!

Feedback from the Practitioners

I get really good feedback from patients from the Llŷn area when I go to see them on the ward. They are pleased of the opportunity to talk to someone about what matters to them.

Many positive things come out of my work while I'm at YG, the connection that has been created with the discharge team is extremely valuable. I feel that there is 'respect' and 'trust' established, they know how to approach me if they need an answer about a patient, and vice versa.

The contact with YG is very valuable, in terms of knowing exactly where patients are medically, that is medically fit for discharge, Llŷn allocations were looked at on Tuesday, but this is now on Thursday, because I'm able to give an update on patients following my day here every Wednesday

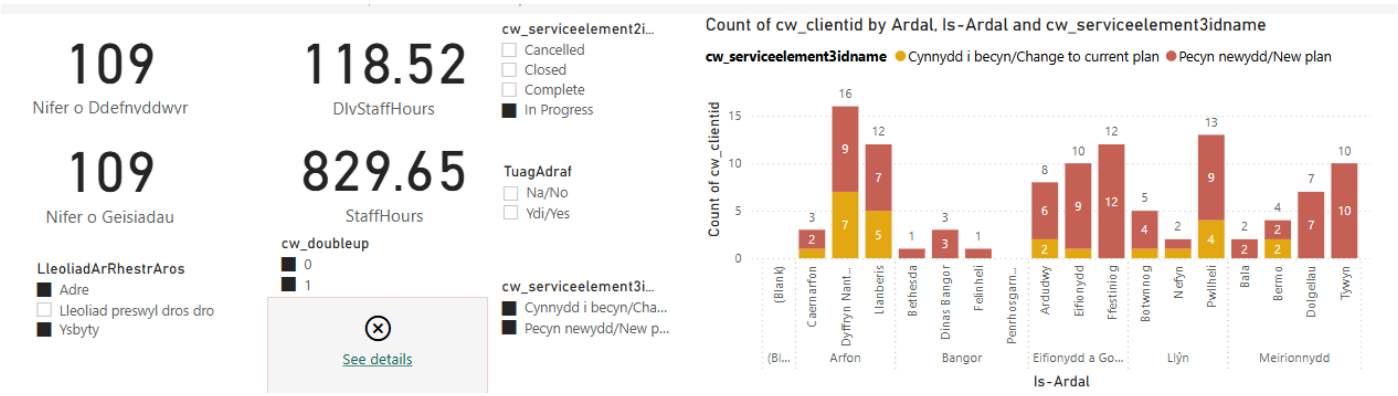
4.52 I am very confident that positive stories such as this will continue and the joint working between Social Services and Health will continue to strengthen for the benefit of the people of Gwynedd and to ensure that we realise the pledge:

"HELP ME LIVE MY LIFE AS I WISH."

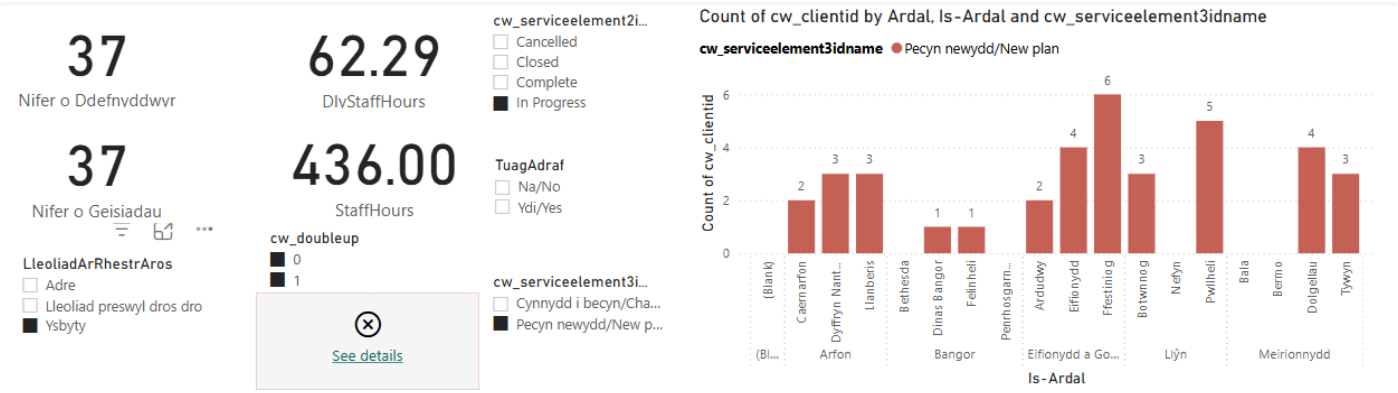
Data on the numbers of patients awaiting hospital discharge and waiting for a domiciliary care package/community care package

4.53 We have a comprehensive dashboard that shows every patch and wider, number of persons waiting for a care package in hospital and in the community. It also shows the figures according to the number of hours and whether calls are with one or two carers.

4.54 The following is an analysis of the domiciliary care hours who are on the waiting list per patch, considering the persons who are in hospital and those persons who are home waiting for a care package.



4.55 Throughout Gwynedd, 109 persons wanted new or increasing support. In the following picture, you can see the numbers who are in hospital, namely, 37 out of 109. An application for approximately half the hours come from the hospital for about a third of the people.



Does providing a care package to those who are ready to be discharged from hospital affect those waiting for a care package in the community?

4.56 Certainly. providing a care package to those who are ready to be discharged from hospital has an impact on those waiting for a care package in the community, but not necessarily in a linear fashion. There are several factors at play here, and therefore, it cannot be stated unequivocally that providing care to someone coming home from hospital exempts a person in the community from having a care package at the same time – although the figures suggest that demand for higher hours is coming from the hospital.

4.57 It is useful to look at the wider picture and the entire situation rather than 'one in, one out'. It is also useful to look at the issue as one whole system, rather than considering the demand coming from the hospital and the demand coming from the community as separate entities, since a change in one part of the system has a direct or indirect impact on the other. Moving away from the concept that one is competing with the other – the community v the hospital, we are in a more positive place to improve the entire system.

4.58 For example, it is known that a long-standing stay in hospital (beyond the date when a person is medically optimised for discharge) has an impact on recovery. The possibility of acquiring an infection e.g. pneumonia is increased, and musculoskeletal mobility and capacity are affected.

4.59 See the following table from a study in Geriatric Society in 2019 [2] demonstrating the impact of a longer than necessary hospital stay on patients:

Functional decline	X 3 more likely
Delerium	X 2.6 more likely
New incontinence	X 1.7 more likely
Pressure injury	X 1.2 more likely
Any hospital-acquired complication (HAC)	X 2.4 more likely
Strong and graded association between HAC and:	Length of stay: 9.1 days LOS for any HAC vs 6.8 days with none (p<0.001)
	6-month mortality (26/192 [14%] vs 17/242 [7%], p=0.02)

4.60 Therefore, it is inevitable that there is an increase in the intensity of conditions as a result of a longer stay than needed and that this will have an impact on care and support resources in the community, e.g. the need for long-term domiciliary care rather than enablement, and this will go from the need for support in the home to a need for residential care.

4.61 Below is a summary of a patient's story from a presentation by Dr Conor Martin, Geriatric Care Consultant in Ysbyty Gwynedd.

Situation before hospital admission:
Retired 79 year old farmer living alone in a two-storey house, no package of care (POC), mobile with zimmer frame upstairs, using wheelchair downstairs, stair lift in between, friend helping with errands.
Admitted 09/11/2023 with fall -> Right Periprosthetic Hip Fracture
10/11/23 (day 2): Total Hip Replacement Revision, short stay in critical care
12/11/23 (day 4): On Ortho ward for post-op acute rehabilitation
16/11/23 (day 8): Ready for community hospital for further rehabilitation
27/11/23 (day 19): Transferred to community hospital - Using steady transfer aid, aiming to get back to baseline mobility
However:
13/12/2023 (day 35): Hospital-acquired Pneumonia (HAP) 1 – treated with oral antibiotics in community hospital. Decompensation in functional abilities and rehabilitation goals
27/12/2023 (day 47): 'Slow progress' due to setback from HAP
30/12/2023 (day 50): Transferred to ED YG – admitted to medicine with HAP 2

[2]Mudge AM, McRae P, Hubbard RE, Peel NM, Lim WK, Barnett AG, Inouye SK. Hospital-Associated Complications of Older People: A Proposed Multicomponent Outcome for Acute Care. J Am Geriatr Soc. 2019 Feb;67(2):352-356

12/01/2024 (day 63): Transferred back to community hospital for more rehabilitation
14/01/2024 (day 65): Transferred to ED YG – admitted to medicine with HAP 3 and Covid
27/01/2024 (day 77): HAP 4 whilst still in YG
05/02/2024 (day 86): Transferred to community hospital. Now aiming for downstairs living with steady transfers and a package of care for ADLs
27/02/2024 (day 108): Transferred to ED YG – admitted to medicine with Urinary Tract Infection
18/03/2024 (day 128): Transferred to community hospital. Now dependent for all ADLs (all daily living), incontinent, therefore needs care home
15/04/2024 (day 156): discharged to dual registered residential/nursing home
***Summary**:*
Medically Fit day 8
Subsequently spent 148 days unsuccessfully rehabilitating in a hospital setting, coming to repeated harm
Ended up in a care home with significant decompensations in physical health, functional status and overall well-being

4.62 Therefore, one of the main objectives of our work jointly with the Health Board is to ensure that people come home from hospital at the appropriate time, with the appropriate support, to avoid complications such as the above that contribute to a deterioration in our residents' quality of life and increasing the demand for community support.

Data about the numbers who have been refused a care package and why

4.63 We do not currently gather quantitative information directly on these topics. But we remind ourselves of the above "qualitative" examples of individuals who were identified through the Hospital Discharge Scheme and were "refused" from receiving a care package.

4.64 They are positive examples of reaching a joint decision with a person and their family that a care package is not the appropriate solution every time. It also underscores the importance of discussing with individuals and their support network before making decisions about their well-being.

4.65 Principle D2RA (Discharge to Recover and then Assess) is that the person's home (be it a house or residential care setting) is the appropriate and the best place to assess a person. The hospital is an unnatural environment to understand an individual's ability to manage in the familiar home environment. Therefore, in another example since the start of this work, a discussion was held with an individual and the family that it would be more appropriate for her to go back home with Tuag Adref support and that a social worker from the local team would visit some two days later.

4.66 This was successful, and after a fortnight of more intensive support by Tuag Adref, a package was put in place for a period to support recovery by re-assessing in six weeks' time.

4.67 The merit of this early solution was that the family could be around the individual better. She was living with family, and so ongoing support was already available, and the family didn't have to spend an hour each way travelling to visit her in hospital. Considering all the relevant individuals in the scenario, it was very beneficial to all and took extreme stress off the family.

4.68 Following an assessment from a worker or social worker practitioner, a traditional domiciliary care package may be unsuitable to meet the need. It is vital that we stop considering that a domiciliary care package is the main and only solution to support, and that we work with partners to debunk this assumption. Direct Payments are one alternative way to support individuals, for example. This is also the period where support from agencies such as Care & Repair and Telecare (and electronic independent living appliances) should be considered to support – as can be seen in the stories; and to ensure that any benefits that the individual is eligible to receive, are offered.

5. Consultation

5.1 We have continually consulted and cooperated with key members of the Betsi Cadwaladr Health Board, including staff of the Adref yn Gyntaf office, Hospital Discharge Facilitators and officers and strategic and operational senior managers. Indeed, the work from the very beginning has been a collaboration between us as a Council and Betsi Cadwaladr University Health Board, operating in an integrated way to put the citizen at the centre of the work and ensure that we succeed.

5.2 In addition, the Community Resources Teams have given their views about the work as required, ensuring a timely and commensurate insight into the need and demand.

5.3 Recently we have held a series of meetings and workshops for officers who are working on the new project, seeking their views about the advantages and disadvantages of the new way of working, as well as asking for new ideas or any improvements they can think of. We've had positive feedback from everyone so far, as well as ideas for more efficient ways to implement the model.

5.4 It is important to note that undertaking this has not only improved the way of working, but it has also boosted staff morale, who have been under a great deal of consistent pressure to address the demand for some months, if not years. In turn, the culture of the Community Resource Teams, and the team involved in the project, has transformed into a much more positive culture, with a fresher overview of the work.

6. The Well-being of Future Generations (Wales) Act 2015

6.1 Have you included residents / service users? If not, when and how do you intend to consult them?

6.1.1 As we have been trialling a new way of working, we have not formally consulted with service users thus far, but those who have been patients at Ysbyty Gwynedd who have experienced a new way of working by being assessed by a practitioner/social worker and have a better experience in hospital to be discharged in a timelier manner.

6.2 Have you considered *collaboration*?

6.2.1 In an effort to ensure better collaboration and integration between the Health Board and the Council, a Project Manager has been appointed since May 2024, this is a joint post between both organisations. The Project Manager works with teams from both organisations to promote collaboration, reduce duplication of efforts, share information and data, and break down the barriers of working in silos.

6.2.2 We collaborate very closely with the Betsi Cadwaladr University Health Board on this work, and as already mentioned, their input is essential to ensure the project's success. We are continuously communicating with the Health Board to ensure seamless operation, to avoid duplication of work, and share good practice and information.

6.2.3 In terms of sharing information in this context, work has already been undertaken and there is more in the pipeline. A dashboard has been developed which provides information about the patients from Gwynedd who are in our hospitals across north Wales and are known to social services.

6.2.4 It combines information from the Health Board's 'Data Warehouse' with information from our system, namely WCCIS. Therefore, the hospital location of patients from Gwynedd can be seen, along with how long they have been in hospital, when they are expected to leave hospital, the area in which they live, who the provider is, how many hours of support they receive, and details of the social worker. The information is available on a patch basis to our social workers and more broadly to health board staff. The information is shared through the principles and procedures of WASPI (Wales Accord on the Sharing of Personal Information).

6.2.5 This is the only example of its kind in Wales, and it was one of the exemplar projects of the Bevan Commission last year.

6.2.6 Very early discussions are underway to improve this system and to expand our methods of sharing information, however, as it is early days, it is beyond the scope of this report.

6.3 What has been done or will be done to prevent problems arising or worsening in the future?

6.3.1 This project addresses the barriers that currently exist in the health and care system, which will get worse in the future according to the figures in the Llechen Lân report if we do not do something. The problems we already face have been identified in this report, and this work

will get to grips to improve the hospital discharge system to ensure that the patient arrives home/in the community in a timely manner.

6.4 How have you considered the *long-term* and what will people's needs be in years to come?

6.4.1 The Llechen Lân report has given a firm foundation to the work and is evidence (as has been mentioned at the start of the report) that the older population is increasing, and that the demand has also increased as a result. Carrying out this type of work at Ysbyty Gwynedd will ensure that we have a suitable resource in the setting to address these challenges and make the most of the resource we have.

6.5 To ensure *integration*, have you considered the potential impact on other public bodies?

6.5.1 As has already been mentioned, we have been working closely with Betsi Cadwaladr University Health Board, but also, we collaborate with several third sector organisations who work in Ysbyty Gwynedd such as Care and Repair, Carers' Outreach, etc. It is vital that we include any relevant organisation involved in the patient's journey back home/into the community.

7. Impact on Equality Characteristics, the Welsh Language and the Socio-Economic Duty

7.1 An Equality Impact Assessment has been completed in draft form, and we hope to finally complete this next month.

8. Next Steps

8.1 Recently, Cyngor Gwynedd has received a Transforming Care Pathways Grant 2025 of £1,149,449 which is very positive and relevant to the contents of this report. The purpose of the grant is to support activity towards carrying out timely assessments and providing care packages to ensure that people can leave hospital when they are medically optimised to do so, helping to reduce the level of delays that occur in discharging patients from hospital.

8.2 Also, the fund will be used to strengthen community care services to assist people to stay healthy at home. This is funding to focus on supporting improvements, and where appropriate, developing or commissioning new or extended services and systems that help address the main areas where this delay occurs.

8.3 The intention with this grant will be to:

- Strengthen our assessment and review capacity, including in the hospital. Develop our information and support service to reduce the demand for an assessment.
- Maintain and expand our domiciliary care provision, particularly in some challenging areas of Gwynedd.
- Commission beds in homes so that they are available for respite periods and/or 'step down' from hospital.
- Co-ordinate culture change within the social work teams, including, workforce training, AI licences to reduce administrative burden, piloting a volunteer co-ordination system in our communities.

8.4 The Grant will also enable us to work jointly with Health and develop the workforce to adopt this approach Moving with Dignity. This approach ensures that care is delivered in a manner that prioritises the individual's dignity, independence and safety while making the best use of available resources.

8.5 We also intend to work together with the Health Board to develop and improve our information-sharing methods.

Background Information

The right care, in the right place, the first time: Six goals for emergency and crisis care

A healthier Wales

Appendices

Appendix 1: Background information about StatsWales

In Gwynedd, we are considering delays before hospital discharge in the context of the number of days and the number of individuals. So, when looking at StatsWales' analysis of the figures around delayed discharge from hospital, there are a few things to keep in mind.

1. It's a monthly census – the information on the number of patients waiting to be discharged from hospital takes place on the third Wednesday of the month. So, whatever the numbers are on that day, and the reasons for the delay, that's what is being announced. E.g. On the third Wednesday of July 2025, six people in Gwynedd were in hospital, medically optimised and therefore ready to come home, but were unable to as a social worker allocation was required for them
2. The information is created by the Health Board and verified by the Council
3. The information is not unambiguous
4. It's for the whole of Gwynedd, therefore, it is not possible to identify local trends
5. The information is high-level and indicative, therefore, it is impossible to act directly based on the figures
6. The wide and varied factors that affect and influence the numbers must be borne in mind
7. The StatsWales reports looks at a wide range of factors – they are coded – e.g. waiting for a social worker, housing and homelessness issues, psychiatric or nursing assessments, equipment
8. The StatsWales reports take into account areas for the whole of Wales, some reports by Health Board area, and others by County. However, it does not compare the numbers with e.g. the population in the area, therefore, in order to be able to compare Gwynedd with other counties in this way, further work would need to be done.

StatsWales information (extract from the StatsWales website)

General description

A delayed discharge occurs when a patient who is clinically ready for discharge cannot leave hospital because the necessary ongoing care and support or suitable accommodation for them is not yet accessible.
The data represent the number of adults occupying an NHS hospital bed, who were 'clinically optimised' ready to return home or move on to the next stage of care, that experienced a delay in their transfer of more than 48 hours beyond the point they were

clinically optimised. 'Next stage of care' refers to all destinations outside of NHS hospitals.
The figures are a census snapshot of current delays being experienced on a specific day in each month across Wales. They do not reflect the total number of delays that occurred over the month.
The data are used to monitor the number of delays, and the reasons for delays, assisting NHS and Local Authority partners to develop regional plans with a focus on outcome based actions to reduce discharge delays across the health system.

Data collection and calculation

Data are provided by Local Health Boards and validated jointly with Local Authority partners.
The Pathway of Care Delays is a snapshot census that identifies people with a discharge delay and reason at a given point each month. Health Boards are required to extract the data from local systems on a census day in each month, and validate the delays with Local Authority partners. Subsequently, data records are entered via a web-based tool and submitted to NHS Wales.