Homecare Association

Expecting the unexpected: Homecare providers' views of hospital discharge

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Executive Summary

People who leave hospital often feel weak and less confident than when they first arrived. In our research, homecare providers emphasised the importance of getting the discharge process right to minimise stress. To prioritise the person in the discharge process, we must understand and address their individual needs. This involves checking important details, including medication; equipment; continence care; suitability of the home environment; and transportation schedules. This is not always happening.

We surveyed 283 homecare providers across the UK, who represent over 21,000 care workers that provide care and support for over 31,000 people. Over half the providers (55%) in our survey said that discharge paperwork doesn't reflect the person's needs and views. A third of providers (35%) said most of the discharges they were involved in were not safe. Almost half of providers (47%) said most of the discharges they were involved with did not meet needs for continence care. A third (36%) also said most people did not have the right medication on discharge. Half (48%) noted the absence of correct equipment in most of the discharges. And nearly two-thirds of providers (63%) said people are being discharged from hospital too soon, leading to readmission.

Three quarters of providers said the people they support are finding it harder to access healthcare than they did this time last year. 40% of providers reported more avoidable hospital admissions than ever before. More than half of providers noted it was difficult or very difficult for people they were supporting coming out of hospital to get the support they needed from other professionals: mental health (67%); social workers (64%); physiotherapists (59%); dentists (55%); occupational therapists (54%); and specialist nurses (51%). Half of providers said it was difficult or very difficult to access support from GPs (general practitioners).

One care provider expressed how many in the sector feel when they said: 'nothing is ever as it seems with hospital discharges – we have been forced to expect the unexpected.'

People's families, and careworkers often have to contact hospitals, GP practices, and social workers for help to resolve basic issues. For example, the person being supported may not have the medication or equipment they need. Such errors are unnecessary.

Providers report spending an average of four hours per person on the phone chasing up avoidable issues with discharges. Too often care staff are waiting for someone to arrive home and they don't, without communication about where they are. More than half of providers (54%) felt hospitals did not listen to or address their concerns about poor or unsafe discharges.

Many homecare providers are keen to support the NHS to ensure smooth hospital discharges and have enough staff to do so. Two-thirds of providers (65%) said that while there were delays in hospital discharge in their area, they had unused capacity. Two-thirds (69%) said they would like to work with other care providers in their area.

And more providers had seen a decrease in packages of care being commissioned than those reporting an increase in the last year.

Some media headlines suggest a lack of capacity in social care is a key problem. Recruitment within the UK remains a challenge, and there continue to be staff shortages in some places. Employment of sponsored workers has, however, helped many homecare providers to maintain and grow numbers. Unlike care homes, which have fixed bed numbers limiting capacity, homecare supply is more elastic. If hospitals handled discharges safely, fees covered costs, and ICBs (Integrated Care Boards) paid invoices on time, more homecare providers would accept NHS work. Models of provision, such as live-in care, could also be useful for people with higher needs discharged from hospital. Many commissioners seem unwilling even to consider this, though costs are comparable to care homes.

Some NHS commissioners and councils purchase homecare at rates such as £16 or £17 per hour. Our Minimum Price for Homecare calculations show these rates do not cover direct staff costs at the legal minimum wage. Providers also need a contribution to covering the other costs of delivering homecare. These include wages of the Registered Manager and back-office staff; recruitment; training; IT and telephony; PPE (Personal Protective Equipment) and consumables; insurance; CQC (Care Quality Commission) registration fees; governance; business administration; rent, rates and utilities; and a small surplus for reinvestment. Late payment of invoices affects cash flow and exacerbates issues with low fee rates. We have raised problems with late payments many times without resolution.

Two-thirds of providers (67%) said there is more pressure to accept people discharged from hospital quickly than before the pandemic. Over half (55%) said commissioners expect homecare providers to support more people with complex healthcare needs than before the pandemic. Although almost half of providers (45%) reported that commissioners pay the same rate for hospital discharge work with complex care as regular, council-funded personal care, some providers (8%) reported a lower commissioning rate for hospital discharge.

Involving homecare providers could help Integrated Care Systems (ICSs) achieve higher performance. For example, understanding individual need and experience; improving outcomes; solving operational issues; and developing services. Two-thirds of providers said they were not included as equal partners in assessments during the discharge process. Some places have engaged homecare providers as Trusted Assessors. All ICSs could adopt this approach.

The NHS is under pressure, but it is crucial to prioritise the basics.

We call on NHS leaders to:

- Ensure hospitals meet people's basic needs when discharged;
- Improve communication with individuals, families and care providers about discharge needs and plans;
- Include care providers in needs assessment;

- Pay homecare providers sustainable rates on time;
- Listen to homecare providers when they raise concerns;
- Involve homecare providers in shaping improvements in operations and strategic service development.

Recommendations:

1. We support the Home First approach (where people are discharged home to recover before their long-term care needs are assessed) and call for NHS and local authority commissioners to implement it consistently.

2. NHS England must publish the contact details of key people responsible for social care in ICSs and Care Transfer Hubs across the country. This is so providers know whom to contact for help, information, feedback, or with service proposals.

3. The NHS and local authorities need to prioritise outcome-based commissioning for hospital discharge services. They should avoid buying homecare based on time and tasks and via spot purchase arrangements. Assessments and communication must revolve around outcomes. The focus should be on meeting the needs of the person and their family, helping them recover and become independent in the long term.

4. There are concerns that people's choice is being limited by commissioners defaulting to care home options. Care Transfer Hubs and others involved in discharge should make sure people know about and can access care at home, direct payments, and live-in care. This could include developing the market for alternative home-based options (see also LGA on Home First approaches).

5. NHS leaders must follow the existing guidance for discharge planning. This is vital for people's safety and requires leadership from the top of the organisation to effect change.

6. NHS leaders need to conduct audits to find out why hospitals are not following guidance on discharge, particularly regarding equipment, medication, transportation, continence products, and home environment. They must then act based on the results before winter 2024/25. This needs to consider staff training and organisational culture.

7. NHS guidance says: "Hospital clinical and managerial leadership teams should: …closely monitor discharge performance data to ensure discharge arrangements are operating effectively and safely across the system". A discharge system needs to include coordinating equipment, medication, transport, and continence products. NHS organisations should include data and feedback on this in their performance reports.

8. Existing discharge guidance recommends planning discharge as early as possible. Care providers should have the chance to meet patients and join discharge discussions before they leave the hospital, when it is appropriate.

9. It is vital that discharge hubs (and devolved equivalents) consider the accessibility and suitability of a person's home environment prior to discharge, including location of bedrooms, toilets, stairs, etc. It is the responsibility of Local Authorities to consider housing needs and adaptations.

10. Communication is vital. It is important for NHS wards or discharge hubs to provide patients and carers with information about what happens after they leave the hospital. This helps patients take care of themselves and avoid readmissions, as guidance mandates. NHS staff responsible for discharge need training to understand the information required by care providers, individuals, and families.

11. NHSE (NHS England) and councils should work with NHSE Digital to monitor and assess the discharge process. They should publish the data as part of official national statistics. We need to track patient experience after they leave hospital, not just when there are delays in transferring their care (this also applies in devolved administrations).

12. NHS ICS (and devolved equivalent) leaders must have a 'no wrong door' policy in place. This means that if someone raises an issue about hospital discharge, the NHS will handle it internally instead of making the person or care provider reach out to other parts of the NHS.

13. To build trust and cooperation, commissioners should choose reliable and high-quality care services. This means quality in commissioning and procurement exercises.

14. Health system watchdogs should connect with Registered Managers in homecare.

15. ICS (and devolved equivalent) leaders need to create routes for social care professionals to share concerns and receive updates on their resolution.

16. Healthcare staff, especially those in Care Transfer Hubs, need regular training on social care. Healthcare staff should have the chance to shadow or train in social care settings as part of their local training within NHS ICSs.

17. ICS leaders should involve care providers in ICS decision making. Social care providers should also have representation in devolved administration structures.

    - Note that the social care partner member on the Integrated Care Board (ICB), usually a local authority, cannot effectively represent care providers, and therefore, ICSs should work with care providers to develop more effective engagement mechanisms.

- Develop a plan for how the ICS can engage with ASC providers and involve them in strategic discussions and decision-making processes.
- Create a forum for providers or work with local care associations to choose a representative for the ICS Partnership Board.

18. Ensure that ASC providers have a role in the new local place arrangements, the Integrated Care Partnership (ICP) and/or the ICB. One idea is to hire someone to advance the social care agenda and educate others about sector issues.

19. Implement the Adult social care principles for integrated care partnerships and seek care provider input on how this is going.

20. NHS England should issue guidance to ICSs on including careworkers in Multi-Disciplinary Teams. Care workers should have the opportunity to work with allied health professionals, continence nurses, and others, with the support of ICS leaders.

21. Effective, interoperable systems would allow the sharing of relevant care information at hospital discharge between hospitals, social care and GPs and significantly reduce wasted staff time tracking down information (for example, on medication changes) via phone calls to several organisations. NHS England's Transformation Directorate must include social care in the development of effective systems to support hospital discharge and continue to support the implementation of Digital Social Care Records across all providers (the 80% target by March 2024 has been extended to 2025).

22. NHS leaders must challenge the narrative that social care capacity is mainly responsible for delayed transfers of care. Social care capacity is dynamic and depends on what is being commissioned and at what cost. Which part of the social care system's capacity is being considered?

23. Local authority and NHS commissioners can use technology and data to better understand care providers. Relevant factors include their capacity, location, and CQC rating.

24. Central government must provide sufficient funds to local authorities and the NHS to cover the cost of homecare. Keeping people in hospital for longer than necessary leads to poorer outcomes for individuals and greater cost to HM Treasury.

25. Local authority and NHS commissioners must offer fair payment rates for homecare. This is important to enable providers to offer fair pay and terms and conditions of employment, meet regulations and sustain services. For basic care, fee rates should enable wage rates equivalent to NHS Band 3 (+2 years' experience); we calculate the fee rate needed is £30.31 per hour in England, from 2024 to 2025. Complex care costs more to deliver. Costs may also differ in

the devolved administrations (see our reports for Wales, Scotland, and Northern Ireland).

26. ICBs (and devolved equivalents) must understand complex homecare, its costs, and the accompanying regulatory requirements.

27. Central government must legislate to ensure public sector commissioners pay minimum rates for care. This is necessary to cover costs of compliance with employment and care regulations. Failure to do so risks labour abuse, high staff turnover, unsafe or poor-quality care, and market fragility. National tariffs for care, as for NHS services, are worth considering.

28. Local authority and NHS commissioners must follow the Prompt Payment Code and ensure they pay homecare providers the right amount on time. Late and inaccurate payments risk the viability of providers.

29. Local authority and NHS commissioners must offer greater security of hours and income to trusted providers. This will allow providers to invest in their workforce by providing training and recruiting sponsored workers. It would also help them manage cash flow. Ensuring an appropriate balance between block and spot purchase contracts combines certainty with flexibility. Paying in advance for planned hours supports greater security of income for careworkers and stability of providers.

30. Local authority and NHS commissioners should consider the full range of care services, including live-in care.

31. Local authority and NHS commissioners must allow care providers to be Trusted Assessors. This would help reduce waiting lists for assessment. Involving Trusted providers in initial assessments would be beneficial in ensuring services meet needs. It would also give providers more freedom to respond to changing needs once people return home. Local authorities and the NHS must also ensure that there are sufficient social workers available for prompt, face-to-face assessments where this is required (particularly for financial assessment).

32. NHS England should collect and share data on in-house and commissioned care in different regions. This should include information on how the NHS commissions care.

33. Skills for Care must deliver their 15 year workforce plan This requires solutions for pay, career advancement, and work patterns. The Government needs to support implementation of a workforce strategy with enough funding.

34. The Government must ensure there are appropriate mechanisms to support international recruits who cannot continue with their original sponsor to more easily transfer to new roles within the sector with a different sponsor.

35. We welcome the Government's work on developing a care career pathway in England. This will give employers and staff a clearer structure for training, development, and career progression. The Government's investment in training and apprenticeships will also help attract and keep careworkers. There remains, however, the challenge of pay and terms and conditions of employment for all in care roles. Government must invest in growing the UK care workforce, with an additional £8 billion to £18 billion per year needed to meet rising demand and to pay careworkers fairly.

Introduction

We've all seen the headlines:

> The Telegraph reports "Record numbers of medically fit patients are stuck in hospital amid growing shortages of care workers to provide help at home…" (The Telegraph, 10 October 2022)
>
> The Guardian says that "Charities say social care crisis is 'crippling patient flow' in hospitals and has created a 'miserable situation'" (The Guardian, 31 August 2022)
>
> "Bed-blocking up by a third as social care jobs go unfilled" (The Times, 6 July 2023)
>
> "Bed blockers fuel record occupancy rates in hospital, NHS stats show" (The Telegraph, 1 December 2023)
>
> "Hospital discharge delays affecting patients seeking urgent treatment, watchdog says." (ITVX, 17 January 2024).

But this raises questions:

- Is this all down to care shortages?
- How do people experience discharge?
- Are there enough social care staff? If not, why not?
- What's the impact of focusing on hospital bed capacity?
- How do homecare providers view this issue?

The Homecare Association is a national membership body for homecare providers, with over 2,200 members across the UK.

Our mission is to ensure society values homecare, and invests in it, so all of us can live well at home and flourish within our communities. We lead the way in shaping homecare and provide practical support for our members.

We have been talking to our members to find out what is happening in homecare delivery; uncover their stories about hospital discharge; and explore ways to improve the experience of those drawing on services.

Methodology

The aim of this research was to engage with our membership to understand the issues around hospital discharge. We invited homecare providers to share their insights and collected data to help shape national policies. Our goals are to improve the experience of those discharged from hospital and give homecare providers a voice.

In the first part of our research, we used interviews and focus groups to gather qualitative data from members across the UK. We grouped participants by UK administration to explore their experiences of hospital discharge. Sometimes diary availability led to interviews rather than focus groups. In total, we interviewed 21 participants across a two-month period.

Once we had finished conducting the focus groups and semi-structured interviews, we began the second phase of the work. This involved issuing a survey to all members to gain more understanding of providers' experience of hospital discharge. The survey included a combination of multiple-choice questions and opportunities for longer written responses. When the survey closed after six weeks on 3 November 2023, we had received 283 responses. Who, in total, represent over 21,000 care workers that provide care and support for over 31,000 people.

We analysed the qualitative data using a thematic approach. We reviewed transcripts of each discussion to identify common words and phrases. We undertook a deductive approach based on existing knowledge and began coding the data. These codes were then input into an Excel spreadsheet and generated into themes for review.

We wrote up the survey data and analysed the open text questions. Appendix A contains a comprehensive report of the survey results. A combination of the survey findings and interview data informs our main conclusions in this report.

A mixed-methods approach allowed us to use the qualitative data to showcase the experiences of our members, through their own words. Introducing the survey data enabled us to contextualise our findings and add further detail to our conclusions.

Background

To reduce the impact on hospitals during the COVID-19 pandemic, the NHS discharged people more swiftly than before. In March 2020, the government issued guidance to prioritise Discharge to Assess (D2A) as the main option. They also provided extra funding for post-discharge services.

Under the new guidance, hospitals were required to discharge all patients as soon as it was clinically safe to do so. The plan was for patients to be transferred from the ward to the designated discharge area within an hour. Discharge coordinators then had two hours to arrange practical help for patients before they left the hospital.

When the government published an update to this guidance in August 2020, expectations changed. Patients with no complex care needs were to be discharged and sent home the same day, as they were deemed 'clinically safe to discharge'. Many organisations welcomed a national approach to hospital discharge that improved collaboration. While the increased focus was a positive development for the sector, organisations also cautioned the Government that implementing new discharge pathways needed to be done carefully, to provide long-term support for the adult social care sector, beyond the needs of the pandemic.

In October 2020, Healthwatch and British Red Cross surveyed nearly 600 patients, carers, and staff about their experiences of hospital discharge during the pandemic. Of this sample group, 82% said they did not receive a follow-up visit or assessment; 64% of people discharged at night were not asked if they needed transport support; and almost two-thirds (61%) didn't receive information about changes to their discharge process during their hospital stay. The survey highlighted the impact of the procedural changes on those being discharged from hospital in the pandemic, with an overwhelmingly negative response.

The Omicron variant spread during the autumn and winter of 2021, causing a shortage of hospital beds. NHS England issued guidance for hospitals to work with local partners to reduce the number of delayed discharges by 50% by the end of January 2022. The Government created a National Discharge Taskforce to improve the hospital discharge process, with membership from the NHS, councils, and government. Later, this taskforce included care provider representatives.

However, the situation only worsened. Data from the Nuffield Trust found that 60% of patients meeting the discharge criteria remained in hospital in the week ending 23 January 2022, therefore, not meeting the targets set by NHS England.

By December 2021, the Health and Social Care Committee published their report, '*Clearing the backlog caused by the pandemic*'. The report found that 5.8 million people were waiting for planned care (as of September 2021). This figure represented the highest level since records began. The report from the Committee emphasised that illness and pressure on staff have a significant impact. They recommended focusing on workforce planning to aid national recovery and reduce the backlog.

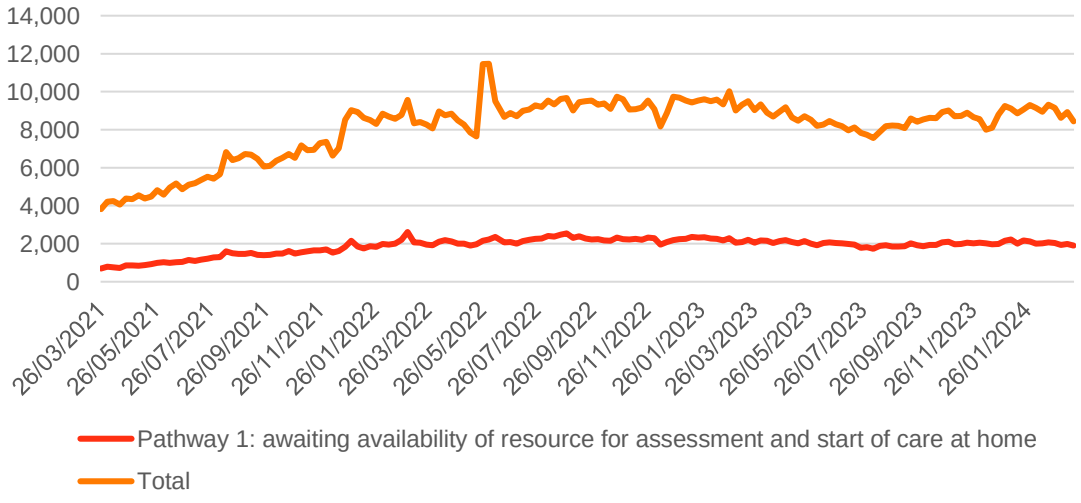
In July 2022, Sir David Sloman, Chief Operating Officer at NHS England, wrote a letter outlining 10 recommendations to improve hospital discharge. In his letter, he announced the launch of the '100-day Challenge', which aimed to use the initiatives to improve the discharge of patients from hospital by 30 September 2022. But by December 2022, over 13,000 beds were occupied by patients who were fit for discharge, an increase of 57% from December 2020.

At the start of 2023, the former Health and Social Care Secretary, Rt Hon. Steve Barclay MP, announced a further £200 million to create 900 new hospital beds to relieve pressures on the NHS. The Government made an additional £50 million available to improve urgent and emergency care. In June 2023 the Government announced that six new ambulance hubs and 42 new and upgraded discharge lounges would open across the country. Four new hubs are now open and offering extra urgent and emergency care. They are at the Princess Royal Hospital in Telford Shropshire; the Leicester Royal Infirmary; the James Cook Hospital in Middlesbrough; and the Doncaster Royal. Two further hubs opened in the summer of 2023 at the Queen's Hospital in Romford, east London, and the Glenfield Hospital in Leicester.

In November 2023, The King's Fund published their report, '*Hospital discharge funds: experiences in winter 2022-23'*. They interviewed staff in different organisations across six areas of England. These included ICBs; hospitals; local authorities; Healthwatch; and care associations. Their aim was to learn about their experiences with additional funding from the Adult Social Care Discharge Fund and the execution of plans for winter 2022-2023. Findings showed that a lack of long-term funding structures hindered ability to spend the funding as effectively as possible.

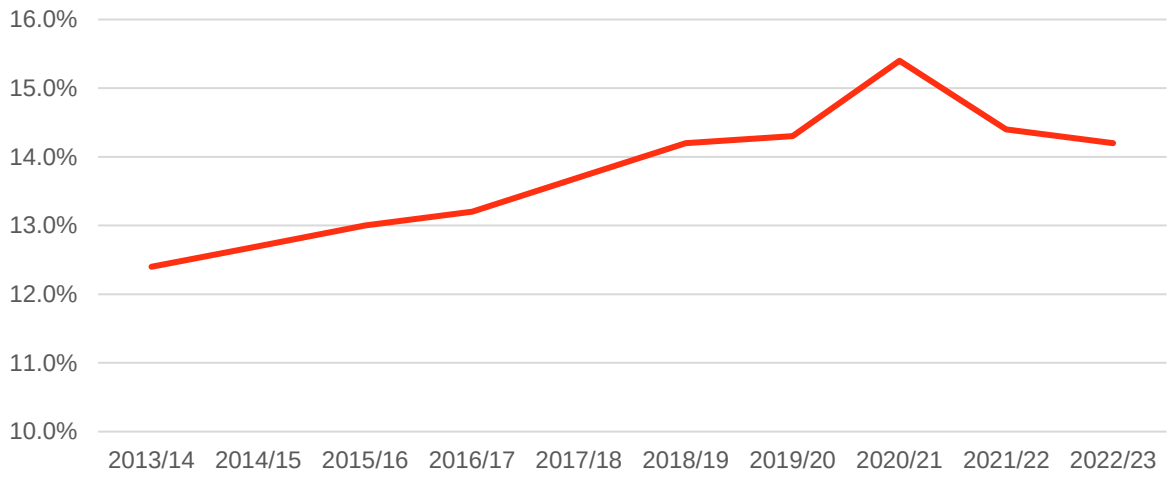
Despite more focus and funding, delayed discharges remain high. Data show the number of people whose discharge was delayed 14+ days doubled during the pandemic and has not come back down. About a quarter of these have been awaiting availability of resources for assessment and start of care at home.

Number of patients delayed by reason with a length of stay of 14+ days
(Source: Statistics » Discharge delays (Acute) (england.nhs.uk))



The percentage of emergency admissions to any hospital in England occurring within 30 days of the most recent discharge from hospital after admission

(Source: Emergency readmissions to hospital within 30 days of discharge : indirectly standardised percent trends broken down by age bands and sex (I02040 / I00712) - NHS England Digital)



Emergency readmissions in England peaked during the pandemic but are returning to pre-pandemic levels. However, this is still significantly higher than 10 years ago.

Current Policy Context

High levels of pressure on NHS care have pushed hospital discharge higher up the political agenda in recent years. This has led to some significant policy developments in efforts to address the situation.

Key initiatives underway in England in 2023/24 and 2024/25 have included:

Implementation of the Intermediate Care Framework**,** including learning from the national discharge frontrunners. Work has also been undertaken on capacity and demand planning for intermediate care.

The framework highlights recommended practice for step-down intermediate care for adults. This focuses on four action areas:

1. Improving demand and capacity planning - making sure the right amount and kind of intermediate care is available to meet people's needs.
2. Improving workforce utilisation through a new community rehabilitation and reablement model – mapping workforce.
3. Implementing effective Care Transfer Hubs (see below).

4. Improving data quality and preparing for a national standard – overcoming information governance issues to share data to help to manage demand and capacity modelling.

Embedding Care Transfer Hubs. All systems were due to have a care transfer hub before winter 2023/24.

Clarifying statutory guidance on Discharge to Assess (D2A) principles. D2A / Home First focuses on discharging people home and then assessing their long-term care needs in their home environment rather than requiring them to be assessed in hospital.

A pilot on a **Hospital Activity Notification System.** This allows social care providers to receive automated notifications when someone they support is admitted to hospital. This can include moving between wards or arriving at A&E, which could save time for care providers.

Additional Discharge Funding. In 2022, the government distributed the Adult Social Care Discharge Fund to support discharge capacity. Two years of additional funding were confirmed via the 2022 Autumn Statement (£600m/£1bn) to supplement the wider Better Care Fund in 2023/24 and 2024/25, respectively. There has also been funding from the Market Sustainability and Improvement Fund – Workforce Fund – to improve capacity (£570m over two years).

A **Discharge Support and Oversight Group** was created to support improvement in the most challenged systems.

NHS Volunteer Responders Programme. In summer 2023 the NHS Volunteer Responders programme was expanded to include social care and covered "helping to transport medicines or small items of medical equipment to people's homes or community settings from NHS sites to aid discharge from hospital".

Standard on eDischarge Summaries. The Professional Records Standards Body has developed a standard on eDischarge, and a toolkit to accompany its implementation. It sets out what information hospitals should include in discharge summaries. This aims also to inform development of NHS acute systems. Good discharge summaries can improve communication about a person's needs during transfers of care.

Whilst care providers welcome many of these initiatives, they will not necessarily address the issues discussed in this report around the NHS working well with care providers and getting the basics right for individuals following discharge without specific strategic focus on these matters.

We could change people's experiences

Hospital discharge is not all about numbers and hospital beds, though these are important. It is about people recovering. It is about staying connected to our communities. It is about job satisfaction, and care teams feeling they are making a difference.

The following scenarios illustrate how getting things right can transform people's experience.

A long way from home

A 90-year-old woman, A, required hospital care because of a severe chest infection and her underlying health conditions.

A was uncertain about her discharge date during her stay in hospital. When the time came, the discharge team offered her a placement in a care home, because she could not be left unattended for extended periods during the day at that stage in her recovery. However, the only care home with availability was seventy miles from where A usually lives, which is near her family. When the hospital discharged her, her family had to travel an hour and a half each way to see her, so they could not visit her often. She also could not see her regular GP. A was less confident in the care home environment and did not recover her mobility. She ended up needing ongoing support in a care home. Though her family eventually moved her to a care home closer to them, she never returned home. She spent a long period feeling isolated from her community and friends in her hometown.

An alternative possibility:

When A was in hospital, the healthcare team offered her support options that met her level of need; for example, care in a care home or one-to-one live-in care support in her own home. When she considered live-in care, an expert care provider visited her in the hospital to discuss her preferences and requirements. This helped them identify a careworker with the right skills and shared interests with A.

When A was ready to leave hospital, she received live-in care for six weeks in her own home. Physiotherapy and support from a careworker helped A regain her confidence and ability to take care of herself at home. Her mobility improved. As she recovered, her family (who live close by) and friends from her local community group dropped in to see her maintaining her social network and supporting her wellbeing. Eventually, her care reduced to occasional visits, until she could manage by herself again, with a little help from her family. A continued to live at home.

Unsafe surroundings

A care provider had been supporting C in his own home for a year. C was in the early stages of dementia but was mobile and able to get around his house safely. C was admitted to hospital following a fall when out for a walk with a friend in a local park.

The care provider received a concerned call from C's neighbours to say they had seen an ambulance drop him back home. The neighbour went over to visit. C was not very well and was asking for his previous careworker. The care provider was unaware of the discharge as were C's family. The care provider immediately phoned the discharge hub to check the situation. The discharge hub confirmed they expected to restart the care package but hadn't communicated this because of an oversight. The care coordinator spoke to C. It became obvious his mobility level was much lower; he couldn't get upstairs to bed; he didn't know what medication to take (there was no discharge note); and he was more confused than before the hospital admission. C had no desire to return to the hospital. The care provider then called the local council to raise a safeguarding concern to resolve the situation and contacted C's family to let them know.

The social worker arranged an urgent visit to C to assess the situation. The social worker agreed to increase the level of care that C was receiving from the care provider temporarily, whilst he recovered.

After talking with the hospital team, local authority, and C, they moved C's bed downstairs until he recovered from the accident. The social worker assisted with arranging for this to happen. However, because it was short notice, it took until late in the evening to arrange, by which point C was exhausted and sleeping in his chair.

Meanwhile, the care provider obtained the discharge note and found that C had a new medication which the hospital did not give him on discharge. The care provider called the GP to get a prescription for this medication. The GP practice said they could not assist because they had not received discharge information from the hospital. The care provider contacted the hospital to obtain a prescription. They then collected C's medication for him.

The care provider asked their staff to rearrange their calls so they could meet C's new care requirements. While staff prefer not to be contacted at such short notice, the provider did manage to arrange cover, but for the first few days it was not with the careworker C was used to.

An alternative possibility:

Early in C's admission to hospital, the discharge team spoke to C and his family about what his house was like and how easily he would manage when he returned home. His family knew C could not get upstairs for a few weeks whilst his leg healed. With C's agreement, the hospital discharge team arranged for his bed to be moved downstairs ahead of his return home. The discharge team updated C's previous care provider on the situation. They realised a higher level of care would be required during C's recovery period and agreed on more frequent visits as C's family were not available to provide support and C did not want to go to residential care, which might also make him more confused. The hospital gave an expected discharge date, so C's calls were planned by the care provider. 24 hours before, the hospital confirmed the date and time of discharge and the care provider arranged for a careworker to be at home to meet C when he arrived. C was discharged home on time and a careworker was there to meet him. He was exhausted after his discharge, so went to

bed early that night. The discharge summary included information about his treatment and changes to his medication. The hospital discharged him with one week's medication, so the GP had time to provide a prescription for the new medication.

Avoiding hospital

When a careworker was on his usual visit to J one day, he noticed she was behaving unusually and was feverish. He called 111, who recommended that J attended A&E for assessment. The hospital diagnosed J with a urinary tract infection and admitted her to hospital. J was distressed by being in hospital and caught COVID-19 whilst there. J recovered after treatment and went back home with her original care package, but still felt anxious about her hospital stay and became more worried about going to hospital in future.

An alternative possibility:

When a careworker was on his usual visit to J, he noticed she was behaving unusually and was feverish. He called 111. After assessment, the hospital discharged J to a "virtual ward" (also called hospital at home). Hospital clinicians provided acute healthcare services to J at home, with homecare as part of the care plan. Care workers remained in regular communication with the virtual ward team, calling them if there was a change in J's condition that might require clinical intervention. Commissioners approved increasing the number of care visits until J recovered. Homecare workers received training to monitor basic vital signs and perform delegated healthcare tasks. Commissioners recognised this additional skill and responsibility in the fee rate offered. This enabled the provider to pay the careworkers higher wage rates. J recovered in her own home, was protected from catching a second illness and felt much less anxious.

Getting to choose

When P left hospital, a social worker considered the options available and ordered a homecare package for him. P and the social worker felt that being at home would be better for P's recovery, and that the homecare package would meet his needs as he recovered. This included helping him wash and dress, prepare meals three times a day, pick up medication from the pharmacy, and do his laundry. The social worker allocated a certain number of minutes of the care worker's time to complete these tasks and commissioned care on this basis. P received three visits a day. On each visit, the careworker worked through the tasks on the list, recorded what they'd done and then left. Some days P's family visited. Other days, he wanted to do something different from his routine, but the care package prescribed by the social worker was inflexible. This impacted the quality of time P could spend with his family. As P became better, he was more able to prepare basic meals for himself so needed less support at lunchtime, but the careworker still had to visit as per the plan. P felt frustrated by his limited control over the careworkers' task list. The careworker wanted to meet J's needs but had to fulfil the requirements set out by the social worker (who was not readily available to discuss revising the plan).

An alternative possibility:

When P was ready to leave hospital, the care provider and social worker met with P to discuss what he needed to support his recovery. Together, they made a plan that outlined how many hours of support P needed each week to achieve his goals. P could communicate with the care provider to change his schedule as required. One day the careworker helped P order his favourite takeaway rather than prepare a meal for him. P changed his routine to alternate between skipping showers one day and enjoying a bath the next evening. Another week his sister visited, so he cancelled his calls on that day and asked for some help with some paperwork another day. As P recovered, he and the care provider agreed to reduce his support to two visits a day as he was making lunch for himself and didn't need help. This greater flexibility was cost neutral, better met P's needs, and was more rewarding for the careworker, who had more autonomy. P's wellbeing was better as a result.

Findings

Introduction

> "*If you spoke with the team we have in place who support discharges they would tell stories that most people would find very distressing."*

When a person is admitted into hospital, it is an emotionally challenging time. After major operation or accident, people may need intense rehabilitation. Or they may need to adjust to life-changing illness or injury.

Care staff and managers establish relationships with the people they support day-in, day-out in their own homes in a way that is simply not possible for most acute health professionals. During our interviews with providers, we heard concern, dismay and frustration about the number of basic problems arising from poor coordination and planning of hospital discharge. Issues also arose from hospitals' lack of knowledge of the needs and wants of the individual being discharged.

Care providers feel infuriated when reading stories in their local news, saying there are queues at A&E because of a lack of social care capacity to support discharge when they have capacity available.

The problems don't stem from one issue but from many. We have grouped the feedback we received under the following themes:

- People's experience of being discharged
- Keeping people safe
- What's it like to work with the NHS?
- Is there capacity in homecare?
- Are there staff shortages?

Section 1: People's experiences of being discharged

Discharging someone from hospital and sending them home safely, with everything they need for recovery, requires ongoing care and attention from all parties.

As per Government guidance, the best way to ensure safe discharge is through person-led care. This approach encourages people to be active participants in the design and delivery of their care plan. It is important to understand people's values and preferences and put those at the centre. People must have access to all the information they need to make informed decisions about their care. They and their families may also need emotional support. Person-led care empowers patients to take charge of their discharge plan, promoting their independence.

During our research, providers told us how they, and the people they care for, have not felt listened to or involved in the hospital discharge process. Providers told us of a frequent mismatch between desired and offered services. For example, funding was used to purchase care home beds when a person wanted live-in care; or the visit times available did not match those the person wanted. This has only added to the experiences of those who feel unheard during hospital discharge. It is the responsibility of Care Transfer Hubs (CTH) in England, and equivalent staff in the devolved administrations, to ensure patients are being informed about and offered the full range of care services. Care Transfer Hubs need to be more accessible to providers, so providers can easily reach out for support or raise concerns.

Only 15% of respondents agreed with the statement: "The hospital discharge process offers people as much choice about how and where they receive support as is realistically possible, given budgets etc.".

We discovered that some people still think care homes are their only choice, and patients feel they're not being given all the options. This causes people to lose trust in the system, makes it harder for patients to leave the hospital, and goes against the goals of Home First and person-led care.

Key issues

Home First and Discharge to Assess (D2A)

The Home First approach is about "*always prioritising and, if at all possible, supporting someone to return to their usual place of residence before considering other options, because home is best*".

Not only does this support the independence of the patient, it also reduces the risk of deconditioning. Discharge to Assess (D2A) was an attempt to implement this and discharge people into their own homes before assessing their long-term care needs. This means assumptions about their care needs are not based on their condition whilst they were in hospital.

Overall, our interviewees were positive about the idea behind Home First and Discharge to Assess approaches. Care providers often see people's health improve

when they regain confidence and are in familiar surroundings. Once settled at home, people feel more able to decide on their future care needs.

Concerns arose, however, about whether the Home First and D2A approaches were being implemented consistently and the time taken to do assessments. One respondent told us weeks passed between a person being discharged home and receiving their care assessment.

Person-led care

Key to ensuring patients have an active choice in their care plan is to implement a person-led approach. The CQC expects everyone in health and social care to have personalised care plans that are regularly reviewed. The CQC's Regulation 9 states:

> *"The intention of this regulation is to make sure that people using a service have care or treatment that is personalised specifically for them. This regulation describes the action that providers must take to make sure that each person receives appropriate person-centred care and treatment that is based on an assessment of their needs and preferences."*

Our respondents said**:**

> *"Some people working across these organisations, they have their preferred choices. But it shouldn't be about their preferred choice, it should be about the preferred choice of the person who will be receiving care."*

> *"Good hospital discharge is where you have someone who actually knows the person who can tell you about the person and you can gather all the information you need. Very often some of the delays and mistakes are because there isn't enough information on that person."*

Providers acknowledged, though, that it's difficult to implement person-led approaches in the state-funded system. The barriers include organisational culture, lack of resources, training and funding. These issues require national-level attention for effective system-wide change.

As discussed later in this report, one way to improve is for everyone involved in the care to take part in joint assessments based on outcomes; this includes the person being supported, the social worker, and the care provider. 69% of our respondents agreed this was a helpful approach to improving the hospital discharge process. This would shift the primary focus from price to the quality of care and the preferred outcomes for the care recipient. All parties must work together to create a personalised care plan, which supports discharge and recovery.

Also discussed later in the report, the practice of including homecare providers in Multi-Disciplinary Teams (MDTs) would improve the hospital discharge process for patients. Care transfer Hubs have a responsibility to facilitate integrated care plans, as part of NHS England's Delivery Plan. Including care providers would make this more effective. They can provide extra information, ensure correct medication and

equipment, and maintain consistent care. Including everyone improves communication and makes handovers smoother.

Providers often receive limited information or notice when a hospital discharges a person. 70% of respondents stated that enhancing communication in the handover process is another way to improve hospital discharge. Poor communication creates frustration. It can also damage relationships between the discharge hubs, providers, and those they support.

Our research showed that commissioners seldom cover the cost of specialised training for care workers; for example, end-of-life care, complex catheter care; or care for those with feeding tubes. Fee rates are often the same as for regular personal care.

Summary

The Department of Health and Social Care (DHSC) and the Care Quality Commission (CQC) emphasise the importance of focusing on outcomes in person-led care. Our research and feedback show that health and care systems have not embedded this approach, which is negatively affecting those giving and drawing on care services.

The following recommendations are based on the real-world examples gleaned from our research:

Recommendations:

1. We support the Home First approach (where people are discharged home to recover before their long-term care needs are assessed) and call for NHS and local authority commissioners to implement it consistently.

2. NHS England must publish the contact details of key people responsible for social care in ICSs and Care Transfer Hubs across the country. This is so providers know whom to contact for help, information, feedback, or with service proposals.

3. The NHS and local authorities need to prioritise outcome-based commissioning for hospital discharge services. They should avoid buying homecare based on time and tasks and via spot purchase arrangements. Assessments and communication must revolve around outcomes. The focus should be on meeting the needs of the person and their family, helping them recover and become independent in the long term.

4. There are concerns that people's choice is being limited by commissioners defaulting to care home options. Care Transfer Hubs and others involved in discharge should make sure people know about and can access care at home, direct payments, and live-in care. This could include developing the market for alternative home-based options (see also LGA on Home First approaches).

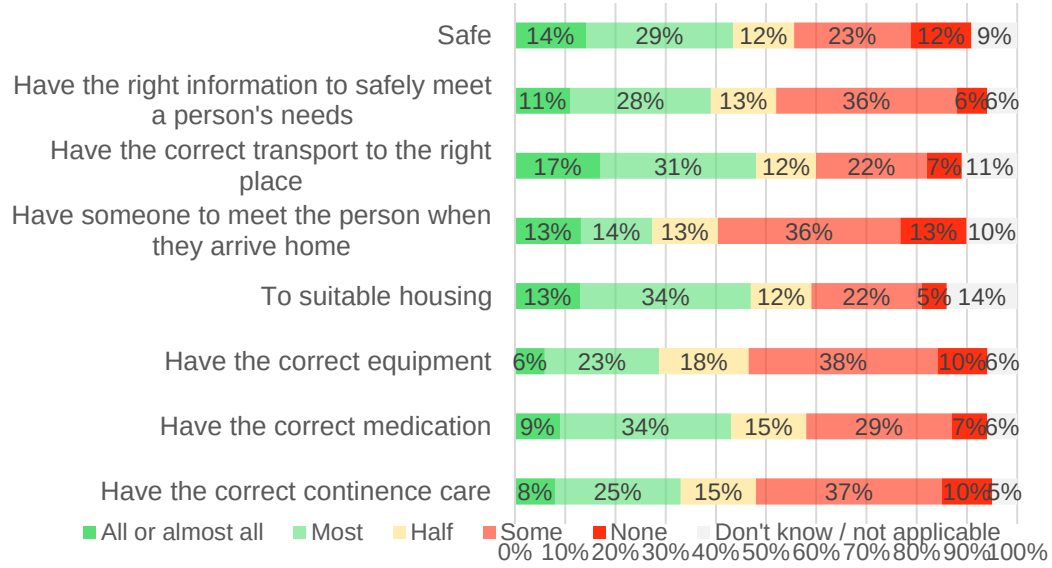
Section 2: Keeping people safe

In our research, there was a common theme of unsafe discharges from hospitals to homecare. Our respondents told us this was because of several contributing factors. These include lack of or incomplete discharge summary, with inadequate information to safely meet needs; lack of equipment; issues with transportation and poor communication with providers, individuals, and family members.

The graph below shows the results.

Q10 How many of the discharges you are involved in at the moment are:

211 responses



A May 2016 report from the Parliamentary and Health Service Ombudsman highlighted the ongoing issue of unsafe discharge. Healthwatch and The Red Cross mentioned them again in more recent reports (as noted earlier). It is disappointing that close to a decade later, we have seen little development in this area.

Key issues

Discharge information/note

Close to half of respondents (42%) believe they are not receiving the right information to safely meet a person's needs. This must improve. The discharge information/note is one of the most crucial documents in the process of discharging someone from hospital. Not only does it summarise a person's stay, it is the key to the continuity of a person's care and lowers the chance of a patient being

readmitted. When providers do not receive the right information, the transition from hospital to home becomes distressing for the patient.

An unsafe hospital discharge process can also introduce complications for providers. Lack of information and the required effort to find it is frustrating for providers.

Government guidance states that hospital wards and discharge teams should:

> *"Ensure people and any family members, unpaid carers and providers of onward care and support have full information about the next steps of care and are given discharge information which includes medication instructions and safety netting arrangements."*

Hospitals should audit compliance with this guidance and address underlying reasons for non-compliance.

Hospitals need better communication channels so providers can access important information more easily.

Our respondents shared examples of discharge processes they have been involved in and the results of a poor-quality discharge note:

- *"Well, we don't really get anything through other than sort of the name and the address when we're taking somebody on from discharge from hospital. So, we just get very little information which you know I don't think is very helpful for us when we're then ringing up the family members to introduce ourselves."*

- *"We've had clients that have been discharged home without discharge papers though we've got no knowledge of what's happened while they've been in hospital, and we've had people that you know they say oh can you take them? But we've just got a name and address and I've actually had it where the address has been wrong."*

Medication

Correct information about a person's medication is vital for their health and safety. A third (36%) of providers said most discharges did not have the correct medication. Respondents found it confusing when their clients' medication changed in the hospital, without explanation.

- *"Sometimes it's very confusing if they've changed their medication in hospital. I'm not always communicated with their discharge documents etc. or with the medication they come on with. It's very often they come home with a carrier bag full of medication."*

- *"Often, they came home with the wrong medication and it's all in a bag and you're lucky if it's alright or you're lucky if anyone knows what it is they're taking and if you had them before and happen to know that wasn't what they*

went in with. And that's a whole different ball game where you trying to sort that out."

Medication is a significant area of clinical concern. Research suggests that preventable post-discharge medication related harm costs the NHS £243 million annually. It is crucial that hospitals update medication lists; people go home with one or two-weeks' worth of clearly labelled medication; and hospitals communicate changes promptly to primary care to include in the person's primary care medical record. Insufficient information transfer can lead to multiple risks for the person being supported and the provider.

Providers gave us examples where the discharge note was of high quality, but we were told this was the exception and not the rule. Places where community hospitals work well with acute hospitals appear to perform better. It is easier for providers to build relationships with smaller community hospitals than large acute trusts. Multidisciplinary teams in community hospitals help with the care plan and fix any problems before patients leave.

Equipment

Providers raised concerns about lack of or incorrect equipment sent with people when they return home from the hospital. Almost half of our respondents (48%) said most of the discharges did not have the correct equipment. 63% stated that people are being discharged from hospital too soon, leading to readmission.

Research has shown that people are at risk of muscle loss because of limited mobility whilst in hospital. Older people can lose between 5-10% of muscle strength within the first seven days. So, when clients go home, an important part of their care plan is to help them become mobile again. Not being able to move around can cause loss of independence and increase risk of readmission. People with life-changing injuries may require new equipment when they leave hospital.

Respondents recommended better planning to ensure patients have the right equipment to meet their needs. Care providers should have more direct access to equipment.

Transport

Over a quarter (29%) of providers reported incorrect transportation for discharges. 49% of participants stated that most of the discharges they were involved in didn't have someone to meet the person when they arrived home. Providers said they were often unaware that hospitals had discharged people they support. Sometimes, the ward staff forget to check if a patient's home is suitable or if someone will be there to receive them before arranging transportation.

Patients with mobility issues or medical conditions may need special accommodations. Providing suitable transportation, like a wheelchair-accessible vehicle or medical transport, helps them travel comfortably with help. Patients who don't have reliable transportation might find it hard to go to follow-up appointments or

get the medications they need. Complications may arise, increasing the likelihood of hospital readmission.

Improving communication with care providers would reduce risk for people on discharge. Addressing transportation needs improves patient outcomes and the quality of care provided.

Specialist Care

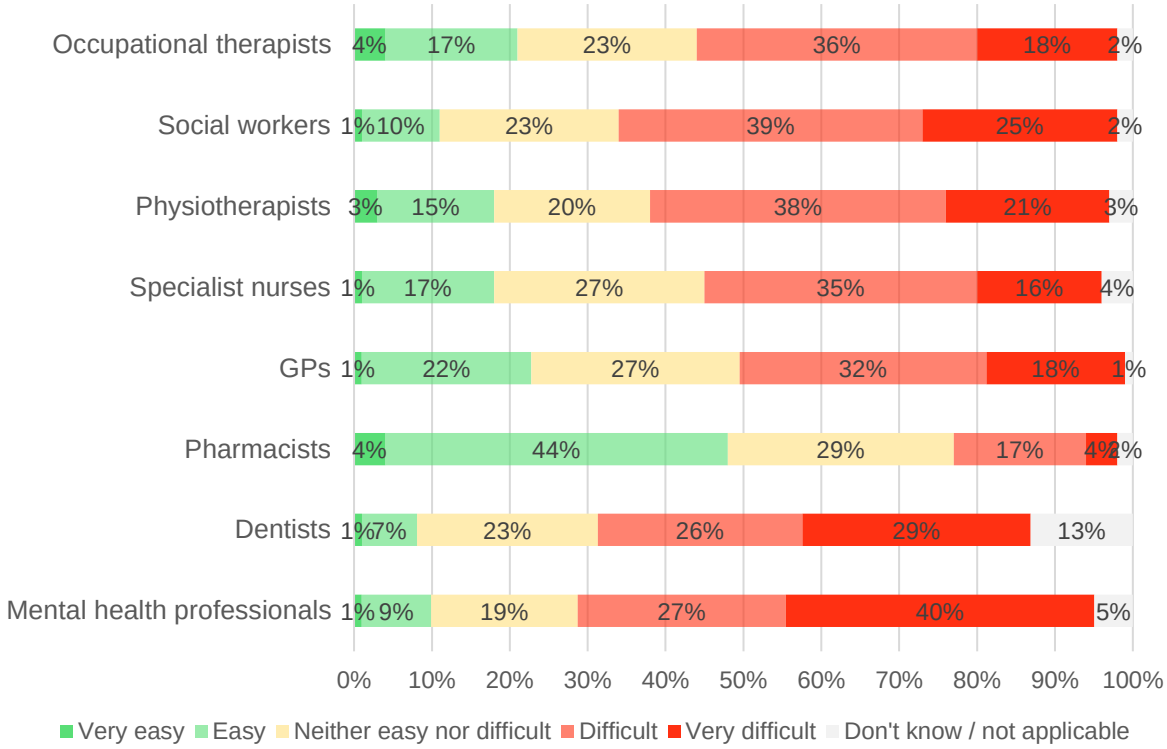
> *"If you're looking for a mental health assessment, you can forget it".*

Keeping people safe also extends to the specialist care and support patients need once they have returned home. Providers expressed their frustrations about getting in-person support from other health and care bodies. Access to this care is the difference between readmission and the reablement of the patient.

During the COVID-19 pandemic, many services moved to providing support online. But 74% of providers told us they did not agree that online support is as effective as in-person support, as it affects the quality of assessments, groups of people have trouble accessing online services, and patients are waiting for long periods of time before being contacted by professionals.

Q19 How easy is it for the people you support coming out of hospital to get access to in person support from the following professionals?

196 responses



In another part of this report, we suggest that care providers join multidisciplinary teams as equal members. They can provide valuable input for assessments and

care plans. An extension of this would be to give staff the autonomy to adjust the amount of care prescribed to patients once they are back home, a suggestion that 59% of respondents agreed with.

Providers told us it is rare for patients to receive a mental health assessment. 67% of providers said getting access to support from mental health professionals for people coming out of hospital was difficult or very difficult.

Emotional impact

Alongside other contributing factors, this is also having an emotional impact on care staff. One provider said:

> *"It's compassion fatigue. People are absolutely worn out".* And another stating: *"You feel like you're battling and all I'm trying to do is provide a safe, effective service for our clients".*

The latest workforce data from Skills for Care states that the sector turnover rate is 28.3%, which is the equivalent to 390,000 leavers for the year 2023-2024. For a sector that has over 152,000 vacancies, we cannot afford to lose dedicated care staff. Hospitals must listen to these concerns and take steps to address communication issues.

Summary

Care providers routinely find that there are difficulties with the information and equipment supplied at discharge. This can also cause additional stress for the patient if they are waiting on medication and equipment. From 196 responses, overall, 59% of respondents agreed with the statement: "Poor practice has become normal". The use of the PRSB standard on eDischarge would create a consistent way to structure and share discharge information.

Recommendations:

5. NHS leaders must follow the existing guidance for discharge planning. This is vital for people's safety and requires leadership from the top of the organisation to effect change.

6. NHS leaders need to conduct audits to find out why hospitals are not following guidance on discharge, particularly regarding equipment, medication, transportation, continence products, and home environment. They must then act based on the results before winter 2024/25. This needs to consider staff training and organisational culture.

7. NHS guidance says: "Hospital clinical and managerial leadership teams should: …closely monitor discharge performance data to ensure discharge arrangements are operating effectively and safely across the system". A discharge system needs to include coordinating equipment, medication, transport, and continence

products. NHS organisations should include data and feedback on this in their performance reports.

8. Existing discharge guidance recommends planning discharge as early as possible. Care providers should have the chance to meet patients and join discharge discussions before they leave the hospital, when it is appropriate.

9. It is vital that discharge hubs (and devolved equivalents) consider the accessibility and suitability of a person's home environment prior to discharge, including location of bedrooms, toilets, stairs, etc. It is the responsibility of Local Authorities to consider housing needs and adaptations.

10. Communication is vital. It is important for NHS wards or discharge hubs to provide patients and carers with information about what happens after they leave the hospital. This helps patients take care of themselves and avoid readmissions, as guidance mandates. NHS staff responsible for discharge need training to understand the information required by care providers, individuals, and families.

11. NHSE (NHS England) and councils should work with NHSE Digital to monitor and assess the discharge process. They should publish the data as part of official national statistics. We need to track patient experience after they leave hospital, not just when there are delays in transferring their care (this also applies in devolved administrations).

Section 3: What's it like working with the NHS?

'Partnership' is a term so often used that it risks becoming a cliché. But the providers we spoke to expressed real and specific concerns about how different parts of the health service and social care interact. This included cultural issues; understanding of social care; accountability; inclusion of social care in Integrated Care Systems; use of multi-disciplinary teams and more. It is important to recognise the contribution of social care and ensure it has parity of esteem within the health and social care system.

Many care providers are keen to work together to solve issues. 69% of respondents to our survey (Q17, Appendix A) said they wanted to work with other providers in their area. Whilst some noted there could be complexities about jointly delivering individual packages of care, many were keen to problem solve issues in their area via a Registered Managers Forum or similar.

Key issues

Cultural issues and understanding of social care

> *"Too many hospital-based staff have no experience or understanding of community care, its benefits and challenges."*

We often hear from providers that NHS staff may make assumptions about what social care staff do. Sometimes this can lead to social care staff being excluded from discussions about a person's care.

In other cases, NHS staff might assume homecare staff can do the same tasks as a hospital healthcare assistant. However, the supervision, funding and other arrangements are substantially different – as is the process for agreeing what tasks a care provider will undertake.

Commissioners must understand homecare when purchasing it. Providers were particularly concerned about the NHS putting cost per hour over outcomes and quality (more about this in the next section).

Provision of certain complex care may require CQC registration for treatment of disease, disorder, or injury (TDDI). Most homecare services register with the CQC to provide 'personal care' only. Not all NHS commissioners appear to realise this. Purchasing care from cheaper, unqualified providers risks unsafe or poor-quality care. Providers who prioritise high standards and invest in training and supervision are frustrated by this.

One of our survey respondents said there was a need to *"stop people being re-admitted on a merry go round of poor care. Care providers should be judged on results not the cost per hour." Cheap care with poor outcomes may cost the NHS more in the long run."*

It's vital that NHS staff understand what social care is, how it's organised, and what care staff need to know. NHS commissioners need to understand what good quality care looks like and the regulatory requirements around that. NHS staff should receive training and experience in social care to better understand how it works.

Accountability

Homecare providers see people arriving home from hospital and witness firsthand how they fare, in ways that discharge teams who make the arrangements remotely do not. Homecare providers may need to report concerns about risks to the safety and wellbeing of the people they support when things go wrong. Problems may arise, for example, if a hospital discharges a person too early, or without adequate support, or to an inappropriate home.

Providers' experiences of raising concerns about hospital discharge have left many with a feeling there is a lack of accountability within the health service. Providers raised safety concerns, but hospitals ignored them, causing repeat incidents. Responsibility was often unclear.

Our survey explored this issue further. While 67% of respondents said that they thought the NHS was accountable for hospital discharge and 74% said they knew how to raise concerns, only 13% felt that the NHS took their concerns seriously and made changes to prevent future incidents. 59% agreed with the statement 'poor practice has become normal'.

While care providers are sympathetic to the staffing and financial pressures that NHS systems are facing, it is a false economy to avoid addressing issues that might lead to poor patient outcomes, readmission, and significant demands on both health and social care services. Limited resources can cause poor practices that harm people's wellbeing and create inefficiencies. It is important not to become apathetic. Care providers are keen to see their concerns addressed.

Providers in our survey often reported concerns about hospital discharges, but didn't always hear from the hospitals. Examples include:

> "We s*pend more and more time reporting to safeguarding boards regarding 'unsafe' discharges now than ever before"*

> *"We are seeing more and more unsafe hospital discharges and despite submitting safeguarding referrals, we rarely hear what the outcome of our concern is"*

Sometimes, a hospital ward might shift responsibility to a GP or community nursing team, when those organisations may not have received discharge paperwork. In this and other examples, the care provider can feel 'caught in the middle' trying to find someone in the health service who will step up to take responsibility for the immediate issue(s).

A respondent also commented that a community nurse contacted them to find out what was happening with a person. Care providers cannot be a substitute for good internal communication in the NHS. One of our interviewees also highlighted the extent to which they felt like they were doing the discharge team's job when they needed to arrange Occupational Therapy assessments, for example, for people who had just been discharged.

Multi-disciplinary teams (MDTs)

Including homecare providers in multi-disciplinary teams varies based on geography and the type of service being offered; MDTs might be more common, for example, in end-of-life care. In some areas, MDTs exist but exclude care providers.

When providers took part in MDTs, it often led to positive opportunities for working together to meet the individual's needs. However, it is important to include homecare as an equal partner and to understand the expert knowledge that careworkers might have about a person's needs. There is a risk that cultural issues can mean that healthcare professionals do not listen to careworkers, or consider them to have relevant knowledge or authority in multi-disciplinary settings. The careworker is often the person who spends the most time with the individual and it is the care provider that helps them adjust their life and care plan based on clinical decisions.

In our survey, we asked 'Which of the following do you think could improve hospital discharge?". Inclusion of homecare providers in multi-disciplinary teams around hospital discharge was the most popular option, selected by 83% of respondents.

Integrated Care Systems

Care providers can offer valuable insights on preventing admission and easing discharge. However, we know that there are varying degrees to which Integrated Care Systems have included providers in their discussions. Providers may have ideas and suggestions, but struggle to be heard. Similarly, providers who want to support hospitals under pressure may not know whom to approach to offer help.

When we asked providers in our survey: “to the best of your knowledge, are care providers in your area involved in strategic decisions about planning health services?” 64% said that they did not know. 16% said there is a local care provider forum run by the NHS or local authority that is consulted on service developments. 14% said that they represented care providers in governance structures such as integrated care systems.

This is not a recent issue. We previously worked with Care England and the Good Governance Institute to produce a report on including Adult Social Care in ICSs. Following this, DHSC produced a set of principles for Adult Social Care Engagement with ICSs. Ensuring implementation of these principles is our priority.

Some ICS areas are making efforts to engage with providers. We’ve had positive feedback about adult social care engagement in Northeast London ICS, for example. Here, providers can offer views prior to decisions and have representation on Place Based Partnership Boards. In other areas, this doesn’t seem to happen effectively. Hospital discharge is just one area that this affects.

All ICSs were due to have implemented a Care Transfer Hub in time for winter 2023/24. However, in our survey, only 12% of providers agreed with the statement “I have been informed about our local Care Transfer Hub and have received details of whom to contact if we have queries or issues.” The Care Provider Alliance has requested that social care providers share a list of regional care transfer hub contacts.

Improving communication with providers is crucial for addressing capacity challenges and planning necessary services.

Access to professionals

Increasing difficulty in accessing NHS professionals can make delivering social care more complex.

As well as the difficulties accessing professionals discussed in section 2 and the move to online appointments, we found wider issues in accessing healthcare. 76% of respondents said that the people they support were finding it harder to access the healthcare they needed compared to last year. 35% stated increased need for hospital treatment among those they support, while 40% reported a rise in avoidable hospital admissions.

Access to healthcare is a problem across the country, but social care professionals also need access to the skills of other professionals. The guidance from continence

nurses and occupational therapists can influence a person's care plan. When care providers can consult these professionals, it helps them respond to significant changes in care services. For this to work, we need agreements to share information and healthcare professionals to understand the importance of homecare providers.

Digital systems

Sharing of digital information can transform communication between hospitals, community health, and social care providers. This could help social care providers understand what happened to someone in the hospital and what medications they need. It could also mean that GPs can respond more swiftly to needs after discharge. To make this work, we need a digital infrastructure that allows health and social care providers to use compatible systems and share data. GP Connect is a positive development, and access to this needs to be extended.

As a basis for shared care records between health and social care, which would mean people had to repeat the same information less often, NHS Transformation Directorate has been working to ensure 80% of care providers are using digital care records. The deadline for achieving this goal has now been extended to 2025. Once most care providers use digital care records, there is the potential to further develop how NHS and care systems can automatically share relevant information to ensure that people’s needs are met.

Digital systems might also support health and social care providers to work together in other ways. This could include notification systems so care providers know when someone attends A&E or is admitted to hospital, for example. At present, care providers might not know someone is in hospital until they arrive at their house and find no one is there. They then need to make many phone calls to locate their whereabouts. A project to explore notification systems showed promise, but solutions are yet to become available.

If complex care providers collaborate with healthcare on 'hospital at home' initiatives, appropriate digital systems and data sharing will be needed.

Summary

To create strong partnerships, health professionals must understand social care and include care experts in decision-making at strategic and operational levels.

Recommendations:

12. NHS ICS (and devolved equivalent) leaders must have a ‘no wrong door’ policy in place. This means that if someone raises an issue about hospital discharge, the NHS will handle it internally instead of making the person or care provider reach out to other parts of the NHS.

13. To build trust and cooperation, commissioners should choose reliable and high-quality care services. This means quality in commissioning and procurement exercises.

14. Health system watchdogs should connect with Registered Managers in homecare.

15. ICS (and devolved equivalent) leaders need to create routes for social care professionals to share concerns and receive updates on their resolution.

16. Healthcare staff, especially those in Care Transfer Hubs, need regular training in social care. Healthcare staff should have the chance to shadow or train in social care settings as part of their local training within NHS ICSs.

17. ICS leaders should involve care providers in ICS decision making. Social care providers should also have representation in devolved administration structures.

    - Note that the social care partner member on the Integrated Care Board (ICB), usually a local authority, cannot effectively represent care providers, and therefore, ICSs should work with care providers to develop more effective engagement mechanisms.

    - Develop a plan for how the ICS can engage with ASC providers and involve them in strategic discussions and decision-making processes.

    - Create a forum for providers or work with local care associations to choose a representative for the ICS Partnership Board.

    - Ensure that ASC providers have a role in the new local place arrangements, the Integrated Care Partnership (ICP) and/or the ICB. One idea is to hire someone to advance the social care agenda and educate others about sector issues.

    - Implement the Adult social care principles for integrated care partnerships and seek care provider input on how this is going.

18. NHS England should issue guidance to ICSs on including careworkers in Multi-Disciplinary Teams. Care workers should have the opportunity to work with allied health professionals, continence nurses, and others, with the support of ICS leaders.

19. Effective, interoperable systems would allow the sharing of relevant care information at hospital discharge between hospitals, social care and GPs and significantly reduce wasted staff time tracking down information (for example, on medication changes) via phone calls to several organisations. NHS England's Transformation Directorate must include social care in the development of effective systems to support hospital discharge and continue to support the implementation of Digital Social Care Records across all providers (the 80% target by March 2024 has been extended to 2025).

Section 4: Is there capacity in homecare?

Two-thirds of providers (65%) said that while there were delays in hospital discharge in their area, they had unused capacity.

This is why one of our survey respondents said, *"no patient need be a delayed discharge - there is enough capacity in the system if every provider is involved - so many companies are ignored, and massive capacity is wasted."* Providers report feeling frustrated seeing news headlines about lack of capacity when they are available to help.

To understand capacity in homecare, we need to consider if providers have the right conditions to operate. This includes having reasonable fee rates to attract and keep staff, working partnerships that meet quality standards, practical commissioning practices, and good planning abilities. It also means thinking about what parts of the care market the Integrated Care System is engaging with at the moment and whether it is using its market shaping responsibilities appropriately.

Key issues

Our members highlighted that the work being commissioned on hospital discharge has changed.

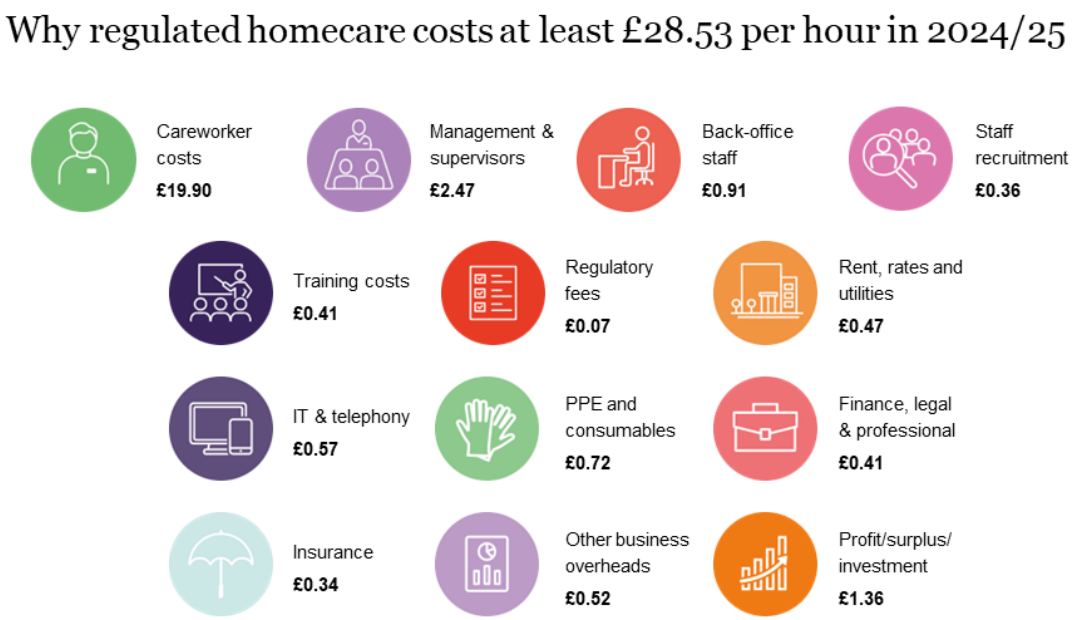
Increasing complexity

In our survey (see Question 3, Appendix A), more than half of the respondents agreed that more complex tasks are being commissioned than before the pandemic. This increase in demand for complex work means an increased need for more highly skilled staff.

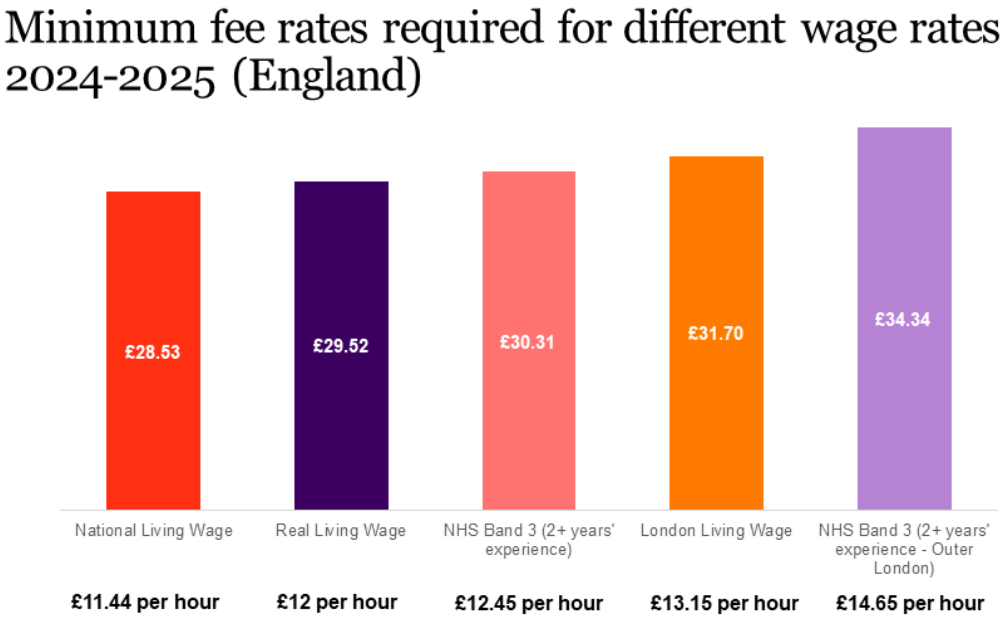
Some providers are embracing this complexity and investing in training their staff. They believe commissioners underestimate the value of high-quality homecare services in supporting healthcare delivery. This could include undertaking delegated healthcare tasks, observations, and monitoring vital signs. Trained careworkers also provide support to people with conditions like dementia or Parkinson's disease.

The implications of additional training, or homecare providers taking on some healthcare functions, is not always recognised by those arranging the care. Because of the skills required, complex care is more expensive to deliver. Careworkers require more training time and should also be compensated to reflect their skill level. Some complex care providers will also need to employ registered nurses. Despite this, we have heard of cases where NHS commissioners were seeking to commission complex care at a rate of £17 per hour. This did not cover the direct employment costs of the careworkers at minimum wage or contribute to other costs.

We calculate a price for homecare that covers staff costs at the minimum wage and supports sustainable, high-quality care. For 2023/24 that minimum price was £25.95 per hour and has gone up to £28.53 per hour for 2024/25.



The Homecare Association believes that careworkers should be valued and paid the same as healthcare colleagues who have similar experience and skills. Careworkers should thus receive at least the same pay as a Band 3 Healthcare Assistant with 2+ years' experience. This would require a fee rate of £30.31 per hour of care delivered.



Complex care may require more skilled staff who are paid higher rates according to their skill level and training. The fact that NHS commissioners have offered £17 per hour for complex care suggests a gross lack of understanding of homecare services.

As a result, some providers are refusing this work because it is loss-making.

Continuity and intensity of support

After a hospital admission, a person's care needs may change. For example, they may need two careworkers to lift them. These changes can sometimes cause conflicts over who will cover the cost of the extra care, leading to disputes between local authorities and the NHS.

It is important to maintain continuity of care for people. Some providers arrive to deliver care and find a cheaper provider has been contracted without their knowledge. Giving care providers as much notice as possible to arrange for changes is important.

Financial challenges

Fee rates affect all care providers, not just the ones that offer complex care. In some areas, commissioners are offering rates as low as £16 per hour, which is not enough to cover employment and delivery costs. This practice is widespread and only 5% of commissioners are paying our minimum price (see our Homecare Deficit 2023 report for a further discussion). As explained above, at least £30.31 per hour is required to enable care colleagues to be paid NHS equivalent pay rates.

Public sector commissioners are not paying enough for homecare. When the NHS and councils pay low fees, it can lead to poor quality or unsafe care and labour abuse, such as not paying care workers for all working time. It can also result in call clipping, where providers bill for a full hour but only provide care for part of that time. Turning a blind eye to this and holding prices down risks driving good quality, responsible, providers out of the market, whilst encouraging high staff turnover and poor outcomes for individuals. It is vital that action is taken to prevent commissioners prioritising price over quality to this extent. One solution is to implement national tariffs that prevent commissioners from lowering costs below the cost of delivery. Central government must allocate adequate funding to councils and the NHS to cover the costs of social care.

Paying for someone to receive support at home will usually cost less than keeping them in hospital, which can cost £345 per day. So even with four hours of visits per day, this would be less than half of the cost of that person needlessly occupying a hospital bed.

Fee rates are not the only financial issue that care providers are facing. Providers also report problems with late payment of invoices for hospital discharge related work. Our 2023 research found that a quarter of survey respondents were seeing average payment length of over 90 days from the NHS.

Insurance companies tightened policies to avoid liability claims from care providers supporting those with COVID-19, or other contagious diseases. This policy wording has not reverted, although COVID-19 has become 'business as usual'. We understand this wording is unlikely to change. Providers may decline to care for

individuals with communicable diseases to comply with insurance policies. This could cause delays in hospital discharges.

The NHS could also create unmet costs through disorganised behaviour. For example, cancelling at the last minute or not arriving at an agreed time, meaning careworkers needed to work additional hours without the provider being paid for this work, making hospital discharge work relatively unattractive compared to community packages where this happens less frequently.

Purchasing care at the lowest possible prices could also generate costs through poor quality care and poor outcomes. It could also mean responsible providers may leave the market. In some regions, intermediaries are used to organise care for discharges, which is not always popular with providers.

Range of services available

Some providers offer live-in care and support. Live-in care supports people 24/7 in their own homes as they come out of hospital and is an alternative to care homes. In many locations, the NHS and councils do not commission live-in care. It may only be available if a family pays for this themselves, including through the use of direct payments. The services available to people vary by region. Providers who would like to propose new types of service may struggle to identify who to speak to within their ICS.

Homecare providers worry hospitals don't always consider the option of providing care in a person's own home. In the longer term, the prospects of rehabilitation in a person’s own home and then stepping down the amount of care needed are a possibility for some people. Using care home beds for hospital discharges can also reduce the availability of respite care beds for families providing unpaid care who look to care homes to provide them with short breaks (depending on local market conditions).

How commissioners are working is also changing. More than half of providers agreed they were seeing more care work being done in-house and not commissioned out. One council reportedly recruited a team of 400 in-house careworkers. The reasoning for and consequences of these choices were often unclear.

Commissioners do not always have effective data systems which help them understand homecare supply and demand. Making this data more accessible to commissioners would improve their decision-making.

Time pressure and discharging 24/7

Two-thirds agreed there is more pressure to start care packages quickly than before the pandemic. 43% said ICB and council staff asked them multiple times to take an individual care package. Sometimes, last-minute pressures put providers off coming forward to accept this work.

Half of our survey respondents (49%) said they face pressure to accept late referrals just before (or on) the weekend, even though they are not contracted to do 24/7 discharges.

One provider noted that their extra-care settings were often treated as though they were 24/7 controlled environments and weren't given as much notice of discharge; however, this was in fact needed to ensure safe staffing levels.

Some discharges could take longer, particularly where staff needed to be trained in the moving and handling requirements of an individual before they are discharged, and this needed to be planned.

While some providers were contracted specifically to provide a 7-day service to support discharge, in practice, they often found that hospital teams could not do this for various reasons; for example, if they required specific tests, medication, or clinicians to finalise a discharge.

Hospitals may be keen to ensure there is sufficient bed space to cover unplanned weekend admissions and may not want to keep someone in hospital over the weekend unnecessarily. However, rushed discharges that are not properly coordinated can cause issues. Waring et al. (2014) reported that weekend discharges account for 34% of all post-discharge deaths. To keep discharged individuals safe, care providers must have access to NHS staff for support with discharge-related issues. Resolving issues late on a Friday is difficult. Many care providers also arrange their staff rotas for the weekend during the week and will not have the capacity to arrange for additional careworkers to come in over the weekend at very short notice unless they are specifically commissioned to run a seven-day service.

Surge funding

In recent years, central government has provided extra funds to support capacity for hospital discharge; for example, £250 million announced in 2023. They often delay releasing the funds, which have a limited time frame. This makes it difficult for providers to plan and ensure the right staffing levels for managing winter pressures. Planning and hiring require prior notice and confidence in funding, which short-term grants don't provide.

Providers welcome joint budgets between health and social care to support hospital discharge. It is frustrating for everyone to see people stuck in the hospital because of arguments about who should pay for their care.

Assessment

There were several issues raised around the assessment of people's needs. Providers believe including them in the assessment process could prevent over or under-prescribing homecare. Feeling unable to trust the information given to them by hospitals was a significant worry for providers planning their services. Finding that someone needed two careworkers rather than one, because moving and handling

needs had been under-estimated, for example, was a particular worry. This can complicate funding and staff rotas. They also raised concerns about the delays in assessing long-term care needs once the person was discharged home.

Care providers hold important information about those they support; for example, records on a person's baseline mobility and mental capacity. If a person they support is in the hospital, discharge assessments rarely include the care provider. One survey respondent noted a case where a hospital would have been better able to assess an individual's needs if they had consulted the care provider:

> *"Hospital assumes patient has Dementia and sends home again. Patient has full capacity; this information would be able to be given by the home care provider and the hospital would know that this confusion is not normal"*.

Care providers can talk to individuals about when and how to offer services while assessing. Access to practical information about care delivery helps answer questions during the assessment; social workers alone cannot address these.

However, 68% of respondents (Q12, Appendix A) disagreed with the statement "we are included as equal partners in the assessments undertaken throughout the process", with only 13% agreeing. Half (49%) of respondents disagreed with the statement "We are able to make contact with the person before they leave hospital", with only a quarter of respondents agreeing. We heard providers express a desire to visit people before they left hospital, but this was often not possible.

> *"Because like our guys have got a good relationship with the small hospital, so we'll visit. Sometimes a planned discharge, can, you know, be a week or two as they get people ready to go home and they'll involve us in that process… In the big hospitals, you just could never arrange to visit a discharge team to have those conversations with them. They just haven't got time."*

The importance of the quality of information handed over to providers from assessments was crucial. However, this was inconsistent:

> *"Some of them, you read them and you're like 'Oh my God, that is absolutely amazing'. You want to give that social worker a round of applause. But just, like, they've described this person. You can imagine them. Do you know what I mean? You can see them, the way they've written this - what they're going to need. And the others you get in you're just like – 'that and that doesn't really work."*

Care providers have regulatory responsibilities to undertake care assessments and keep these under review. So, they will usually conduct their own assessments even if social workers or others have assessed that individual.

There are Trusted Assessor arrangements in some places that might allow one individual to undertake a care needs assessment on behalf of the provider and the NHS or commissioner.

However, CQC guidance advises that “providers should only enter into Trusted Assessor agreements if they are confident that referrals will be appropriate and based on sound knowledge of their service and the needs it can meet. They must also be confident that the participating NHS Trust will respond to any concerns promptly, including through making appropriate arrangements for the discharged person when needed.”

The evidence in this report calls into question the level of trust care providers have in discharge teams. It may be possible for providers to be ‘Trusted Assessors’ in more cases for assessing care needs. Social workers still need to be involved where financial assessments are required.

Inclusion of providers in assessments and discussions about what outcomes a person wants from a service need not only be on a Trusted Assessor basis.

Waiting lists

Question 6 of our survey suggests slightly fewer enquiries about commissioned homecare are being made to providers than previously (whereas this pattern is not the same in privately funded care). Over late 2023 and early 2024, we have also heard providers comment in some regions (and this varies considerably across the country) that there are hardly any people listed on waiting lists for hospital discharge in their region, where previously the lists were extensive.

In some areas, commissioners have added many additional providers to their framework agreements. In other areas, councils have taken services back in-house (as discussed above).

If councils add more providers as contractors without buying more hours, each provider will have less work. This affects staff turnover and financial viability. It also creates risk for employers of sponsored workers, who need to work at least 37.5 hours per week to meet their visa requirements.

Even though some places have expanded their capacity, there are potential risks to quality, safety, market stability, and the well-being of careworkers. Waiting lists also depend on social worker capacity. Numbers waiting for assessment may reduce if care providers could also undertake certain kinds of assessments.

Some care providers questioned if the disappearing waiting lists meant people were being sent home unsupported when they needed care.

Outcome-focused approaches

Outcome-focused approaches prioritise the individual's needs and find the best way to meet them. 53% of respondents said they thought that “changes to the way hospital discharge services are commissioned (e.g. favouring outcome-based or block contracts)” would improve hospital discharge.

When asked what they thought would improve hospital discharge, 69% of survey respondents agreed with “undertaking joint outcome-based assessments where the

person being supported, social worker and care provider are all present". 59% of respondents agreed that what would improve discharge would be to "Give care staff more autonomy to adjust amount of care prescribed when people are back home after hospital discharge".

Outcome-focused approaches require changes to commissioning practices. They rely on greater trust between the commissioner and provider to deliver the right level of support. Some regions have moved to patch-based commissioning of services. This helps to provide a more sustainable volume of hours per provider and allows more efficiency in scheduling visits.

Paying on planned and block purchase

Some regions block purchase capacity for hospital discharge work. This enables care teams to be flexible in supporting discharges faster, seven days a week. This means the hospital is paying for a service delivered to agreed parameters rather than purchasing care by the minute. Purchasing care this way enables services to cope with fluctuating demand and to ensure availability. Block payments also help care providers pay staff for shifts, which leads to more secure income for careworkers. Candidates who prefer regular hours may find the work more appealing, which could help with recruitment challenges.

Paying in advance on planned hours is another arrangement which is helpful for care providers and their careworkers. More commonly, commissioners pay at least eight weeks in arrears on actual care hours delivered. Without guaranteed income, it is hard for employers to offer payment for shifts or full-time employment contracts, which are needed for sponsored workers. Payment in arrears also makes it difficult for homecare agencies to manage cash flow, especially when payments are late.

Summary

Capacity in the homecare market is fluid, depending on staff availability and the willingness of providers to take on certain kinds of work.

To ensure capacity in homecare to support hospital discharge, commissioners must meet several conditions:

- Fee rates must be viable.
- ICBs and councils must pay invoices on time.
- Commissioners must understand the complexity of care needed and ensure they contract with appropriately registered providers.
- Homecare providers need to plan in the medium and long term; outcome-focused block contracts, and payments on planned work are helpful.

Care providers also want to contribute to assessments to ensure the care commissioned meets the needs of the person being discharged.

Recommendations:

20. NHS leaders must challenge the narrative that social care capacity is mainly responsible for delayed transfers of care. Social care capacity is dynamic and depends on what is being commissioned and at what cost. Which part of the social care system's capacity is being considered?

21. Local authority and NHS commissioners can use technology and data to better understand care providers. Relevant factors include their capacity, location, and CQC rating.

22. Central government must provide sufficient funds to local authorities and the NHS to cover the cost of homecare. Keeping people in hospital for longer than necessary leads to poorer outcomes for individuals and greater cost to HM Treasury.

23. Local authority and NHS commissioners must offer fair payment rates for homecare. This is important to enable providers to offer fair pay and terms and conditions of employment, meet regulations and sustain services. For basic care, fee rates should enable wage rates equivalent to NHS Band 3 (+2 years' experience); we calculate providers in England need fees of at least £30.31 per hour, for 2024 to 2025. Complex care costs more to deliver. Costs may also differ in the devolved administrations (see our reports for Wales, Scotland, and Northern Ireland).

24. ICBs (and devolved equivalents) must understand complex homecare, its costs, and the accompanying regulatory requirements.

25. Central government must legislate to ensure public sector commissioners pay minimum rates for care. This is necessary to cover costs of compliance with employment and care regulations. Failure to do so risks labour abuse, high staff turnover, unsafe or poor-quality care, and market fragility. National tariffs for care, as for NHS services, are worth considering.

26. Local authority and NHS commissioners must follow the Prompt Payment Code and ensure they pay homecare providers the right amount on time. Late and inaccurate payments risk the viability of providers.

27. Local authority and NHS commissioners must offer greater security of hours and income to trusted providers. This will allow providers to invest in their workforce by providing training and recruiting sponsored workers. It would also help them manage cash flow. Ensuring an appropriate balance between block and spot purchase contracts combines certainty with flexibility. Paying in advance for planned hours supports greater security of income for careworkers and stability of providers.

28. Local authority and NHS commissioners should consider the full range of care services, including live-in care.

29. Local authority and NHS commissioners must allow care providers to be Trusted Assessors. This would help reduce waiting lists for assessment. Involving trusted providers in initial assessments would be beneficial in ensuring services meet needs. It would also give providers more freedom to respond to changing needs once people return home. Local authorities and the NHS must also ensure that there are sufficient social workers available for prompt, face-to-face assessments where this is required (particularly for financial assessment).

30. NHS England should collect and share data on in-house and commissioned care in different regions. This should include information on how the NHS commissions care.

Section 5: Are there staff shortages?

> *"Go out and interview every single care staff member who delivers, care at home, who support people from hospital to home. Go, go, go out and see what it's like and then ask yourself, is that an £11.00 an hour job?"*

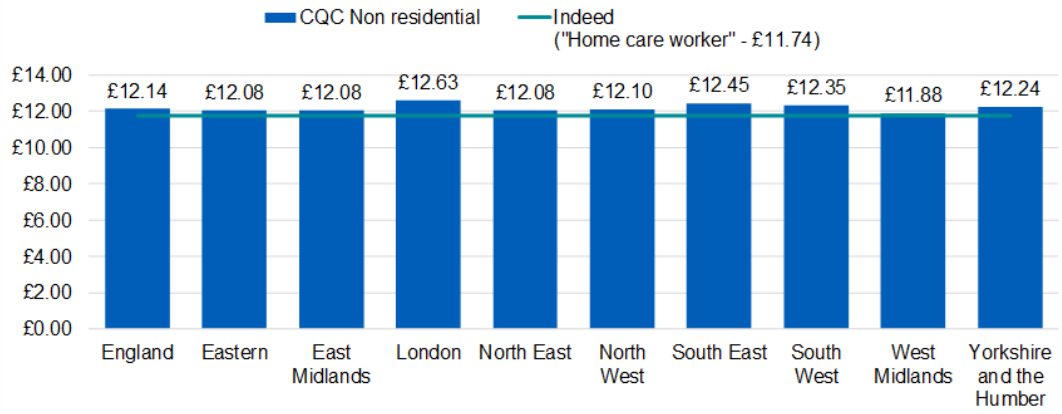
One-third of survey respondents stated the key factor limiting hospital discharge was the number of care workers. A quarter felt it was the viability of fee rates offered. Care work is challenging and requires substantial technical knowledge and many soft skills. Examples include emotional intelligence; communication; negotiation; confidentiality; conflict resolution; initiative; and the ability to operate alone and in teams. Careworkers interact with diverse people, including those with communication challenges. This job isn't for everyone.

In 2022/23, Skills for Care reported the mean hourly pay for careworkers in the independent sector was £10.50. Unpublished data from Skills for Care from December 2023 suggests homecare workers' average pay is £12.14 per hour in England.

Homecare worker pay

Chart 1. Estimated CQC non residential care worker hourly rate by region

Source. Skills for Care estimates December 2023, Indeed.com



Most public sector bodies commission and purchase homecare on a zero-hours basis. They pay by the minute for client contact time only. If a person goes into hospital, for example, commissioners stop paying the provider. This leads to use of zero-hour employment contracts. While these suit some workers who value flexibility, a key drawback is the insecurity of income. Skills for Care estimate that 50% of careworkers working in homecare were employed on zero hours contracts in 2022/23.

Workforce numbers fell sharply after 2020/21. A combination of factors affected this, including the COVID-19 pandemic; Brexit; tight labour markets in many sectors; and high sickness levels in the working age population. The care sector has since struggled to recruit and retain workers within the UK. In 2019/20, vacancy rates were 9.4% in homecare. This rose to 13.2% in 2021/22. The Government added careworkers to the Shortage Occupation List and the Health and Social Care Visa route opened in February 2022. Since then, vacancy rates in homecare have slowly decreased, standing at 11.5% in April 2024. The vacancy rate remains higher than pre-pandemic.

The improvement in the vacancy rate is not from the recruitment of staff already based in the UK. Skills for Care reports a decrease of 30,000 British workers in the sector in 2022/23, with 70,000 international workers joining. This represents a small but necessary increase. As the population ages, the UK will need 440,000 extra care workers by 2035, giving a workforce 2.23 million, as estimated.

However, in May 2024 the Home Office has reported a sharp decline in main applicants for care visas, following changes aimed at reducing immigration. Rules that limit dependants make working in the UK less appealing to foreign recruits. UKVI is also conducting stricter checks to ensure care providers have real job

openings. This follows abuse of visas and exploitation of careworkers by some companies.

Whilst the sector welcomes protection for care staff, the new rules make recruitment of sponsored workers very difficult. We are hearing of processing times of up to 5 months in some cases. There is a risk this could lead to more significant staff shortages, as we saw in 2022. This could affect hospital discharge work, but in ways that differ by region.

While researching, we heard concerns from providers in certain regions about a scarcity of work. Waiting lists for hospital discharges in some places are now negligible.

Hundreds of new homecare providers have started up and at least 45,000 international recruits of a total 94,000 in care, have joined the homecare workforce. If councils increase the number of providers they contract with, this leads to less work (or less predictable work) for each provider.

Poor management of homecare supply and demand in certain areas has resulted in insufficient work for sponsored workers. If the Home Office revokes sponsorship licences for rule violations, homecare capacity in certain regions may fall at speed. This means people may not receive the support they need to remain at home. This could lead to more hospital admissions and longer stays in hospital for those who cannot go home without care.

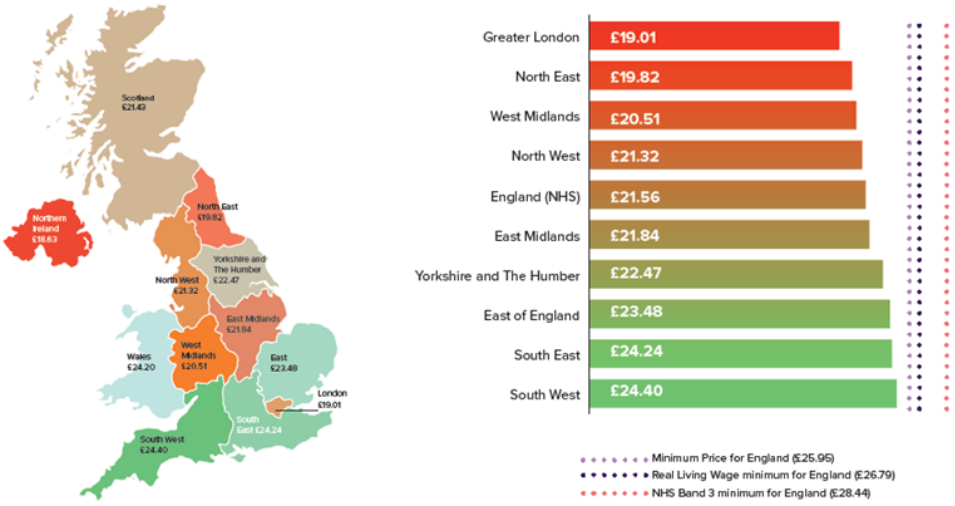
In its update on the People at the Heart of Care White Paper in 2023 the Government launched development of a care workforce pathway. This aims to support career structure and development across the sector in England.

Funding for a new Level 2 qualification is due to be rolled out from summer 2024, though the general election may delay this. The Government has published the first part of that pathway and a second phase is in progress. In parallel, Skills for Care is leading on creation of a 15-year workforce plan for the sector, which is independent of DHSC.

These initiatives are welcome. Growing the UK workforce is, however, likely to remain challenging until we have a sufficient investment in improved pay and terms and conditions of employment.

During 2023, we conducted a large FOI inquiry, obtaining data from all 276 public bodies across the UK which purchase homecare from independent providers. We found that 95% of public sector commissioners were paying rates below those needed to pay fair wages to careworkers and ensure quality and sustainability of services.

Weighted average hourly prices for homecare 2023



Providers cannot fund higher wages and better working conditions for staff; or higher pay increments for more highly trained staff, unless commissioners pay rates that cover costs.

The Government needs to invest in pay, career paths, and training to ensure enough staff for hospital discharge.

It is important to note that the Devolved Administrations also face similar workforce issues, although they have all implemented a pay rate for careworkers that exceeds the minimum wage, this is also not translating into viable fee rates for care providers. They also have mandatory care workforce registration, with accompanying requirements around training.

Workforce strategies and training plans in the nations are different. The core workforce issues, however, remain the same. Careworkers need to be offered competitive pay rates and the opportunity to be paid more when they qualify and are ready to progress. Fee rates paid in all four nations fall well below what is required.

Recommendations:

31. Skills for Care must deliver their 15 year workforce strategy to meet changing needs. This requires solutions for pay, career advancement, and work patterns. The Government needs to support implementation of a workforce strategy with enough funding.

32. The Government must ensure there are appropriate mechanisms to support international recruits who cannot continue with their original sponsor to more easily transfer to new roles within the sector with a different sponsor.

33. We welcome the Government's work on developing a care career pathway in England. This will give employers and staff a clearer structure for training, development, and career progression. The Government's investment in training and apprenticeships will also help attract and keep careworkers. There remains, however, the challenge of pay and terms and conditions of employment for all in care roles. Government must invest in growing the UK care workforce, with an additional £8 billion to £18 billion per year needed to meet rising demand and to pay careworkers fairly.

Conclusion

Investing in hospital discharge services is important. Hospital discharge does not need to continue to feel stressful, chaotic, and impersonal. More is possible.

- An improved system could prevent hospital admission; support more people in their own homes; and ensure people feel safe when they leave hospital.

- Simple changes to improve the basics of hospital discharge would reduce stress, enhance wellbeing, and save time and money. This includes people getting clear discharge notes; the right medication; the right equipment; the right continence care; and timely transport.

- Homecare providers can contribute to improving outcomes. ICSs must involve them in short-term and long-term service delivery and development. Fewer people need to go into care homes against their wishes.

- Commissioners can improve services for those leaving hospital by including care providers in assessments.

- Fee rates for homecare must be adequate to invest in pay, training and supervision of care teams. This will promote staff retention and quality, safety and sustainability of services.

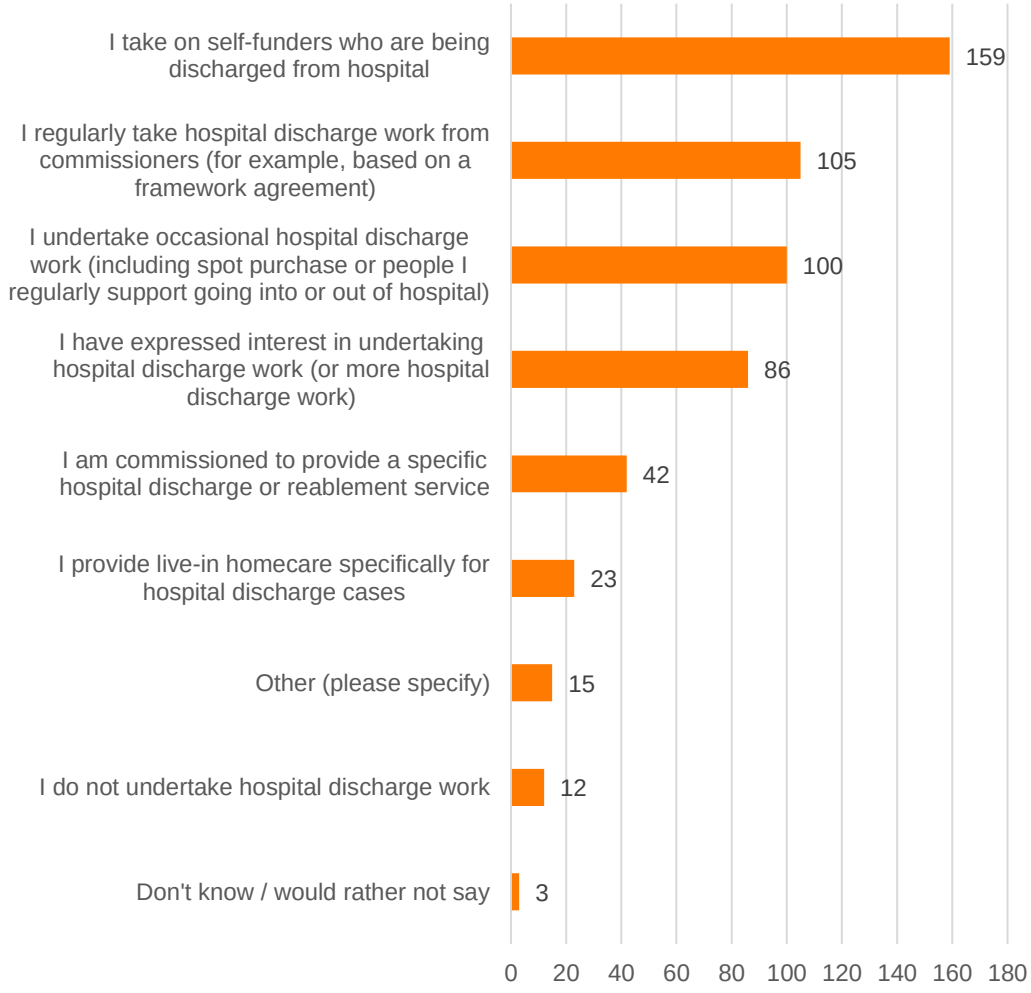
We call on Integrated Care System leaders and the Government to address these issues. We want to see tracking of performance on patient and care provider experience, as well as on data on delayed discharges.

Appendix A – Survey results

Q1 Are you engaged, or have you expressed interest, in work related to hospital discharge? (please select all that apply)

283 responses

Relatively few providers (15%) said that they were commissioned to provide a specific hospital discharge or reablement service. Most providers took on self-funders being discharged from hospitals (56%) or took hospital discharge work from commissioners on a framework agreement (37%) or spot purchase (35%).



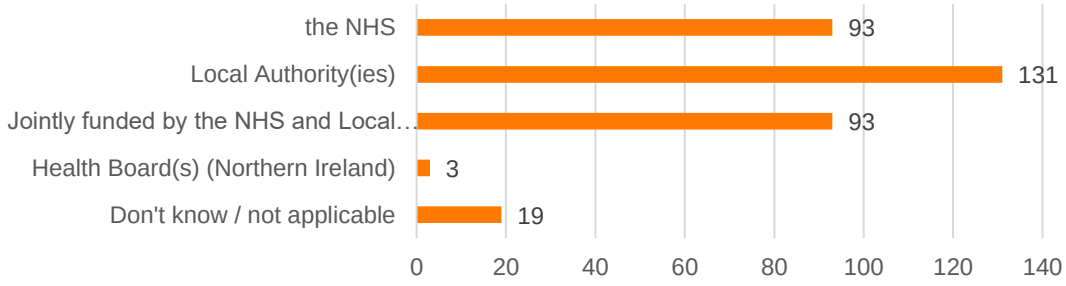
Under ‘other’, several respondents said they want to offer services but were not on the framework, or other providers had offered services at a lower price.

One respondent was an introductory service. One provided specialised care and support to people being discharged from secure units. One had been involved in a hospital discharge pilot project.

Q2 Is the hospital discharge work you undertake funded by:

206 responses

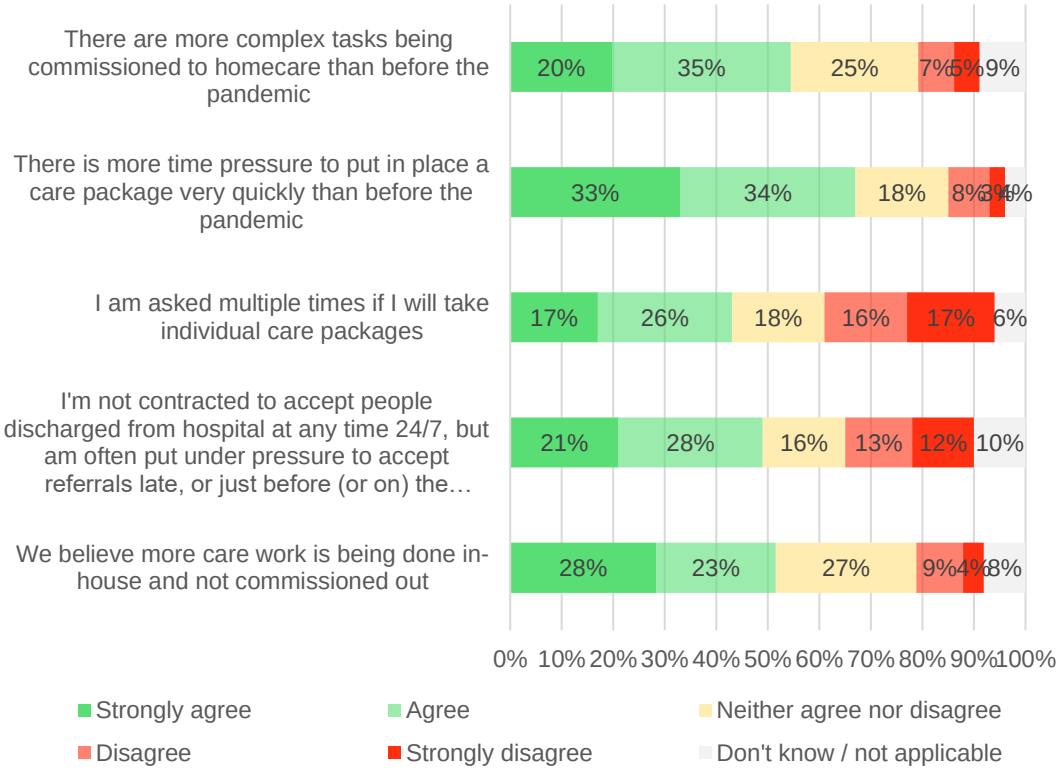
Slightly more providers reported taking hospital discharge work funded by local authorities (64%); with 45% taking work funded by the NHS and 45% taking work funded jointly by the NHS and Local Authorities.



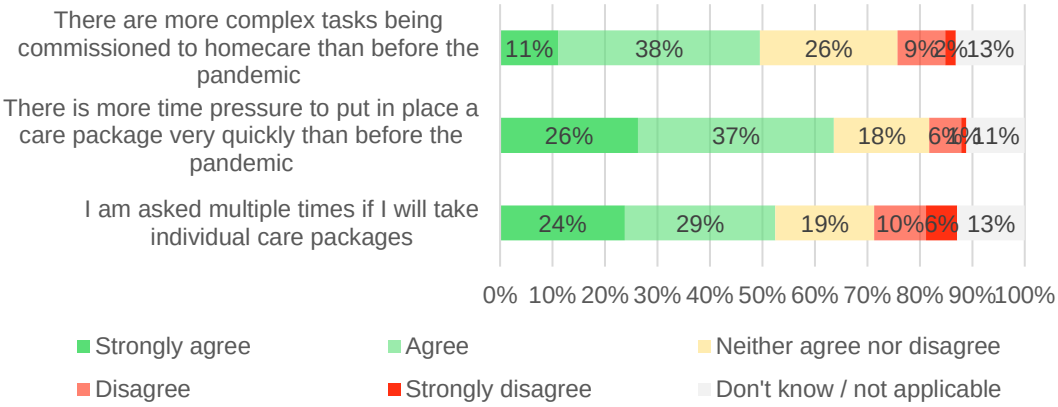
Q3 Thinking about your experiences with commissioners, to what extent, if at all, do you agree with these statements?

223 responses

55% of respondents agreed that there are more complex tasks being commissioned to homecare than before the pandemic. 67% agreed that there is more time pressure to put in place a care package very quickly than before the pandemic. 42% agreed that they were asked multiple times if they would take an individual care package. 49% agreed that they were often put under pressure to accept referrals late or just before (or on) the weekend, even though they are not contracted to accept people discharged from hospital 24/7. 53% of providers said they believed more care work was being done in-house and not commissioned out.



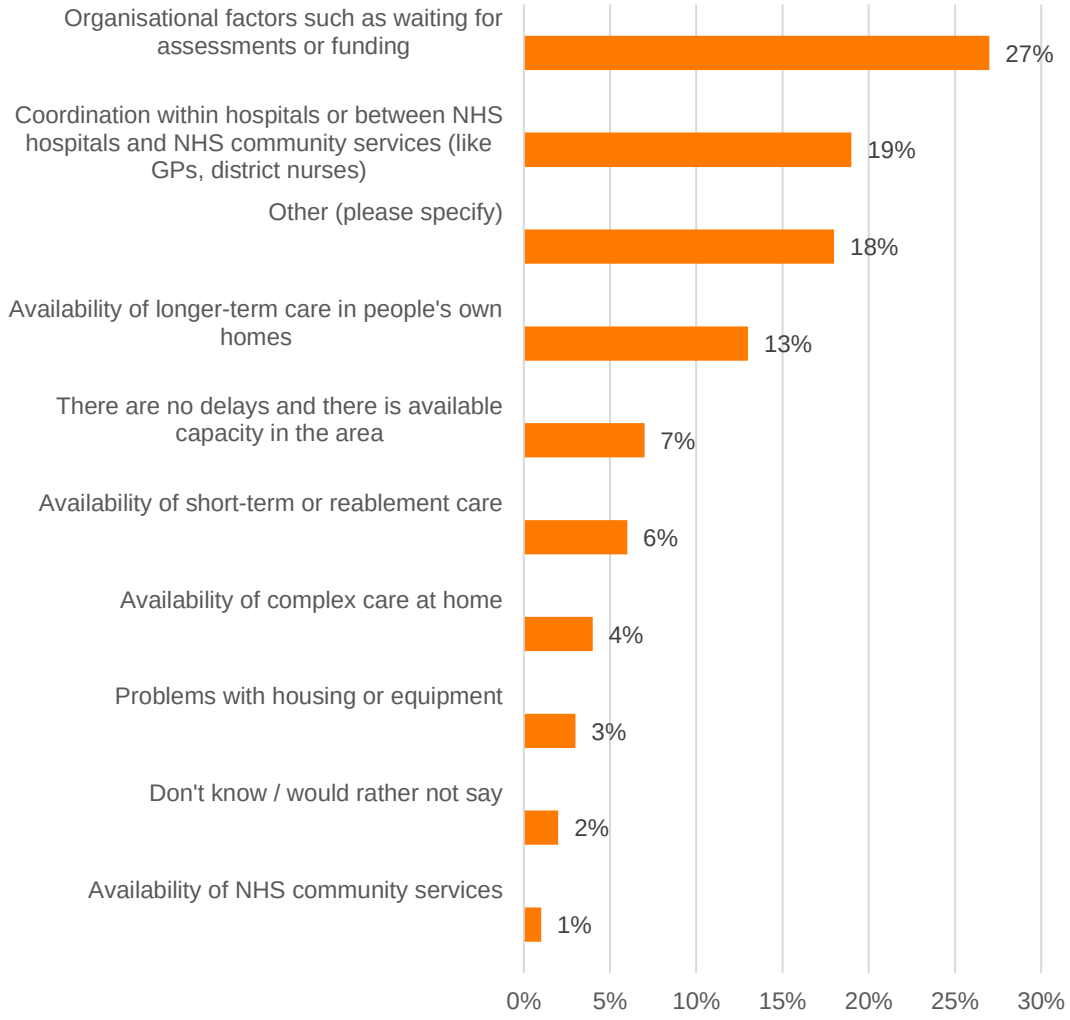
We asked similar questions in a previous survey in early 2023 and results were:



Q4 From your experience, what do you feel is the most significant cause of delays in hospital discharge in your area at the moment? (select one)

223 responses

The top three responses were: organisational factors such as waiting for assessments or funding (27%), coordination within hospitals or between NHS hospitals and NHS community services (like GPs, district nurses) (19%), Availability of longer-term care in people's own homes (13%).



Under 'other', respondents most frequently cited the amount the NHS and local authorities (and in one case a Health Trust in Northern Ireland) pay. Providers reported that fee rates were frequently unviable.

Several respondents also mentioned issues covered elsewhere in this report. Examples include problems with assessments; lack of knowledge of the patients' mobility levels; issues with medication, transport or equipment; or lack of Occupational Therapy support.

Some providers raised concerns about how commissioning is managed or structured, which caused social workers or hospitals to overlook providers with capacity. Sometimes, the system could not accommodate people's

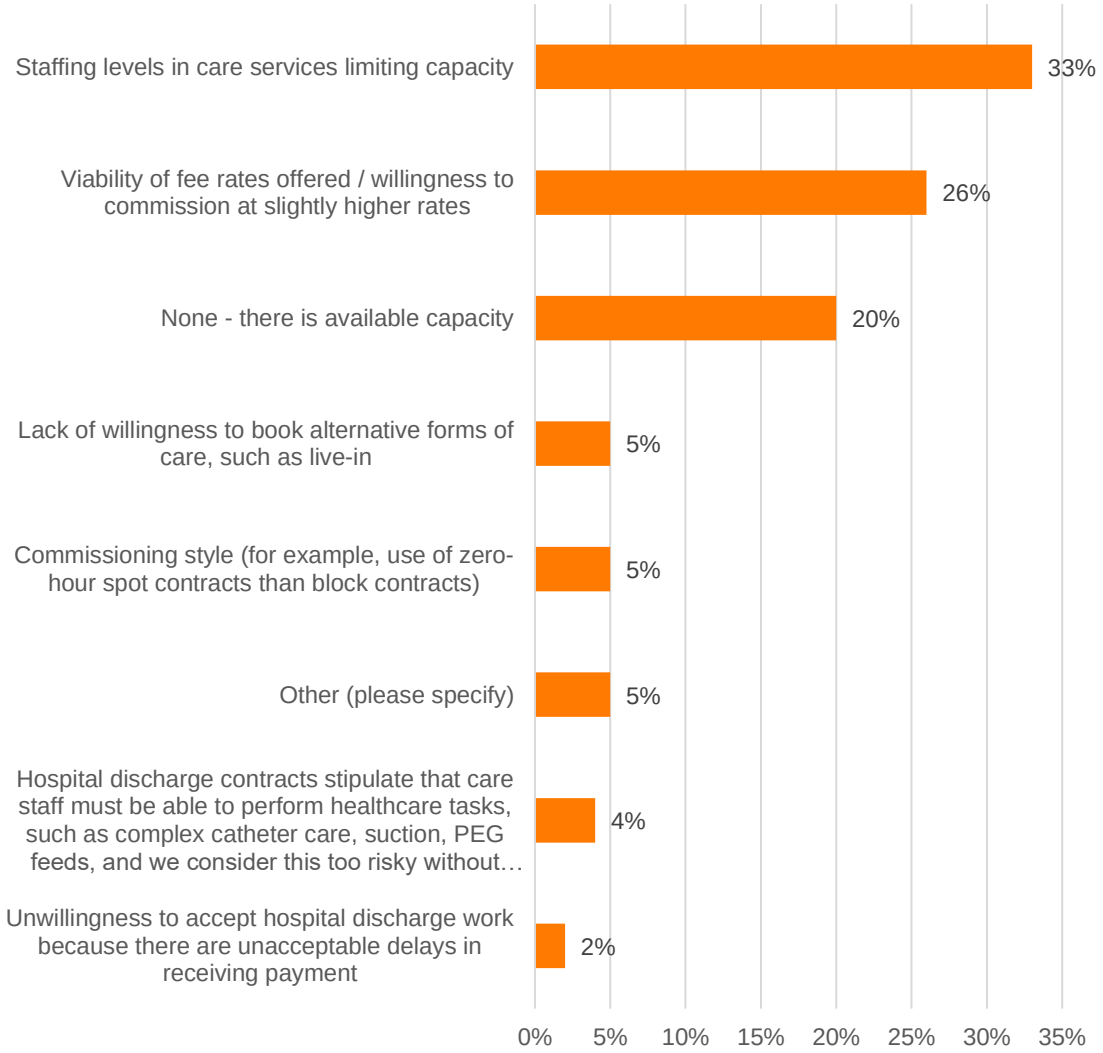
preferences. For example, funding was used to purchase care home beds when individuals wanted live-in care; or the visit times available did not match those the person wanted.

Coordination and communication issues could also be an issue, as well as a shortage of capacity in specific parts of the system.

Q5 Which factor is the most significant limiting factor for the availability of homecare capacity for hospital discharge, in your view, at the moment? (select one)

223 responses

The most significant factors listed were staffing levels (33%) closely followed by viability of fee rates (26%). The two are connected.



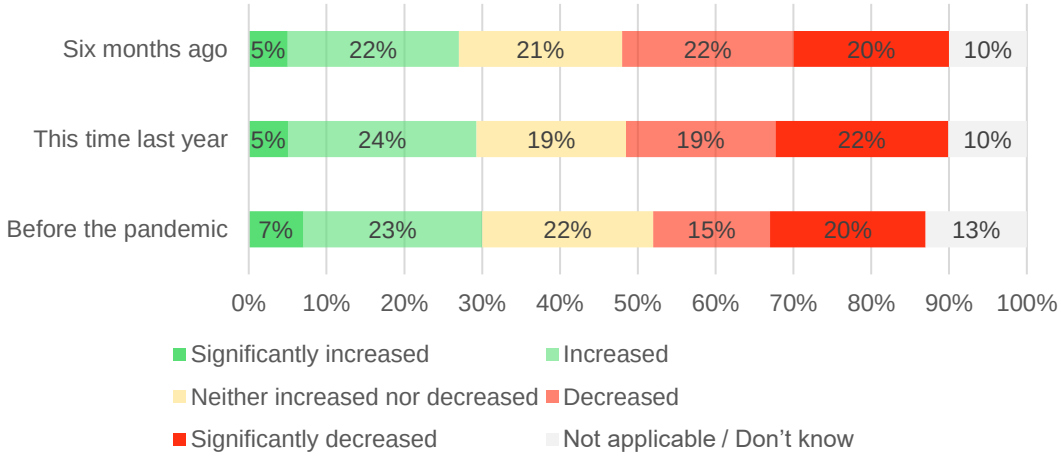
In the ‘other’ category, respondents mentioned problems finding staff at short notice and delays in funding decisions. Some couldn’t decide between the options and didn’t want to favour one. One provider raised the issue of quality

assurance checks undertaken by commissioners and how these overlapped with CQC's role.

Q6 Has demand for commissioned care increased or decreased (i.e. are there greater or fewer care packages being commissioned) now compared to:

223 responses

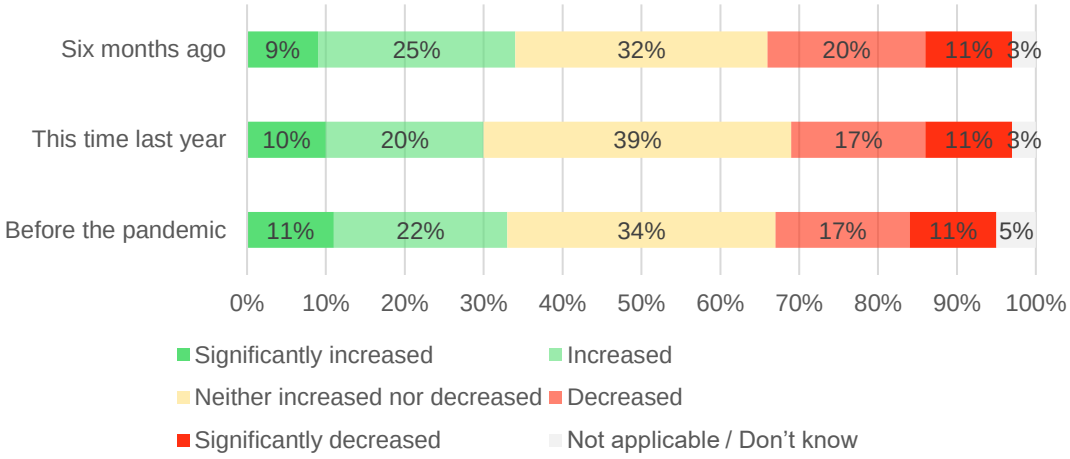
More providers were reporting a decrease in commissioned care than an increase. In the last six months 27% had seen an increase whilst 42% had seen a decrease. In the last year 29% had seen an increase whilst 41% had seen a decrease. Compared to pre-pandemic levels, 30% had seen an increase and 35% a decrease.



Q7 Have the number of enquiries about private/self-funded care related to hospital discharge increased or decreased now compared to:

223 responses

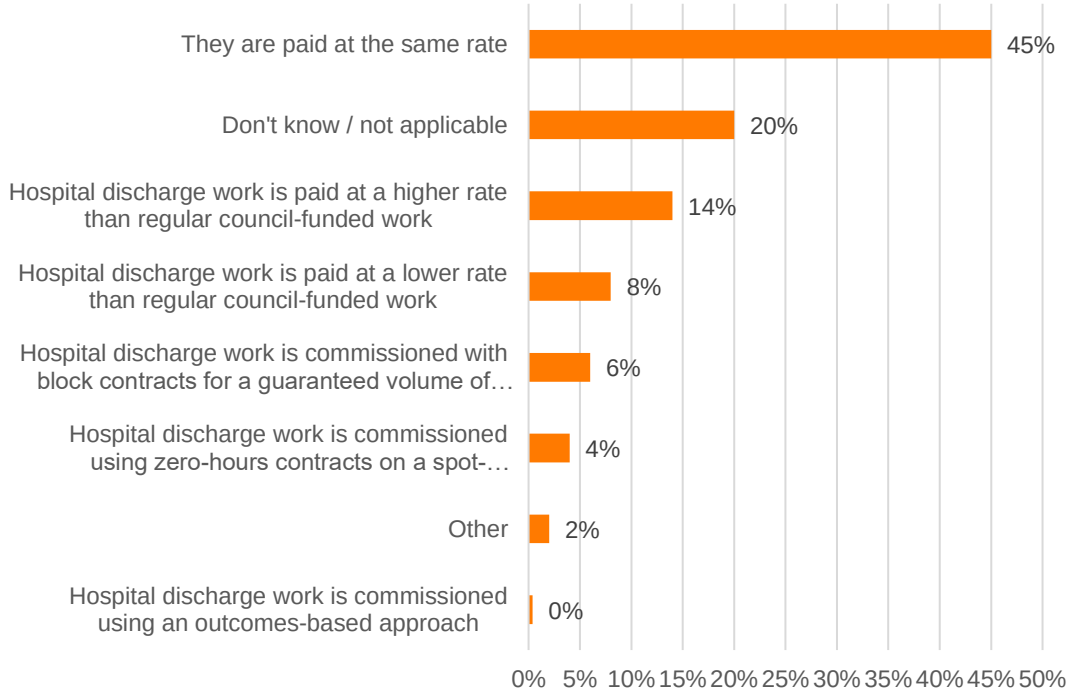
Slightly more providers had seen an increase in private-funded enquiries than had seen a decrease. In the last six months 34% had seen an increase whilst 31% had seen a decrease. In the last year 30% had seen an increase whilst 28% had seen a decrease. Compared to pre-pandemic levels 33% had seen an increase while 28% had seen a decrease.



Q8 Where work is commissioned at an hourly rate, is the rate for hospital discharge work higher or lower than regular council-funded work?

223 responses

The most common response was that providers were paid at the same rate for hospital discharge work and regular council-funded work (45%). 14% were paid a higher rate for hospital discharge and 8% were paid a lower rate. A small number of providers were paid in different ways, for example on block contracts, for hospital discharge work.

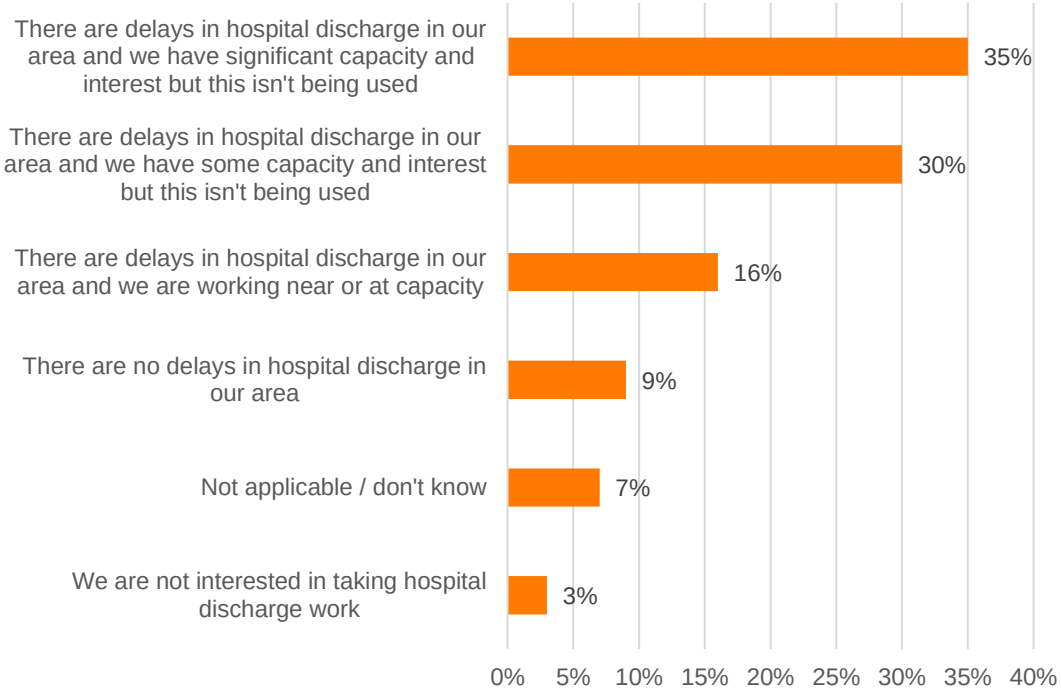


'Other' responses included comments that rates depend on the complexity of the person's needs; or that they varied between region.

Q9 Do you have available capacity for hospital discharge which is underutilised at the moment?

223 responses

65% of providers said they had some or significant capacity that wasn't being used despite there being delays in their area. Only 16% were near or at capacity.



We received 41 further comments on this question, which raised some of the following concerns:

- Transparency - providers may not know who decides about discharge commissioning or who to speak to.

- Late payments and other financial issues – this could sometimes be because of disagreements about who is funding a package of care. One provider said invoices weren't being paid, another said: "we have had to jump through hoops in order to be paid"

- Several providers raised concerns about the use of low-quality-low-cost provision undercutting other providers. The rates that some hospitals were offering were unviable.

    - One provider said: "we have the capacity… but they only want to pay £17 per hour, our staff get paid a minimum of London living wage and we cannot afford to accept that as we would make a loss with our overheads".

    - In one case, commissioners sought to ensure that everyone received care at council rates, which were unviable: “a definite push by the council to put all care seekers down the commissioned route, regardless of their financial situation, so everyone pays the same rate. We would be bankrupt if we accepted their rates as we pay well and treat our staff fairly. There seems to be a race to the bottom”.

    - This issue clearly links to workforce pay, which was mentioned by some respondents.

    - There were concerns in one area about the discharge team being supported by ‘self-employed’ agency staff who worked long hours.

- Respondents mentioned use of intermediaries: “Hospital discharge in our area is arranged by a private company… who only work with preferred care providers”.

- Lack of communication around discharge, leading to poor discharge, led some providers to decline taking on this work.

- Needs assessment – commissioners were unwilling to commission enough hours to meet needs could also lead providers to decline taking on this work.

- Providers were concerned about the lack of waiting lists in some areas; this contradicted their experience and understanding of need levels. Providers raised questions about assessments and whether hospitals sent people home unsupported.

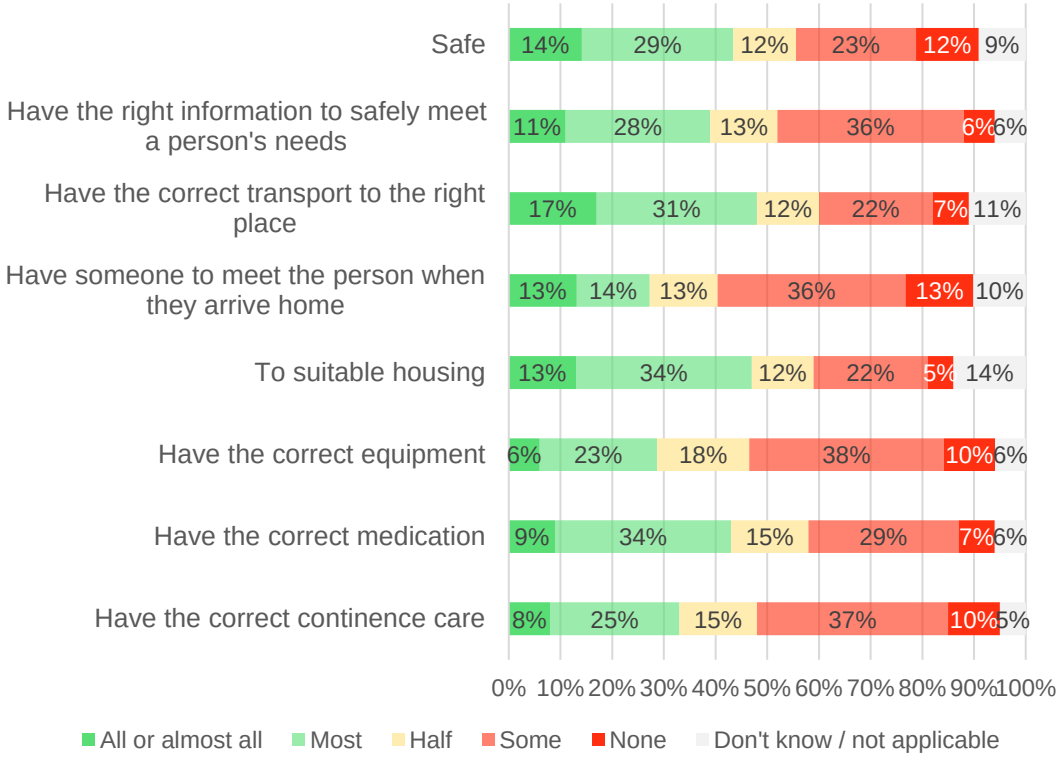
- Complex care has additional registration requirements with the care regulator that restrict the number of providers who can do this work.

- Not looking at all providers. NHS commissioners did not consider the full range of providers in their areas. Some providers only provide live-in care or undertake longer calls. Some providers only work for rates which are higher than the NHS is willing to pay (though the cost would be lower than keeping someone in hospital).

Q10 How many of the discharges you are involved in at the moment are:

211 responses

35% of respondents said that most of the discharges they were involved in were not safe. 42% of respondents said that most of the discharges they were involved in did not have the right information to safely meet a person's needs. 29% of respondents said that most of the discharges they were involved in did not have the correct transport to the right place. 49% of respondents said that most of the discharges they were involved in didn't have someone to meet the person when they arrived home. 27% of respondents said that most of the discharges they were involved in were not to suitable housing. 48% of respondents said most of the discharges they were involved in did not have the correct equipment. 36% of respondents said that most of the discharges they were involved in did not have the correct medication. 47% of respondents said most of the discharges they were involved in did not have the correct continence care.



Q11 How many unnecessary hours on average per person/patient discharged do you spend phoning NHS wards, discharge teams, other hospital services or pharmacies or GPs on matters relating to hospital discharge (including when you have trouble getting through, or get through to the wrong people)? This could be, for example, due to inadequate discharge paperwork or issues with equipment.

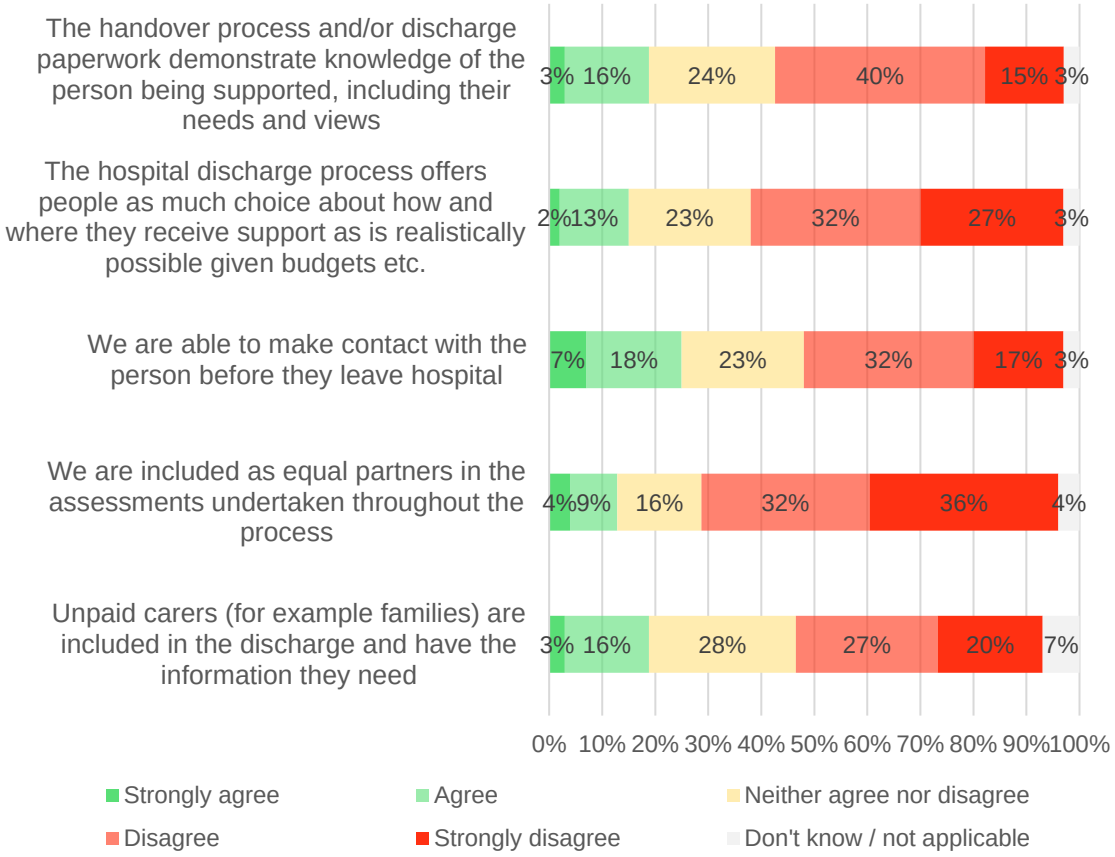
The average (mean) response to this question was 4 hours per person (based on 137 responses).

A couple commented that they have Trusted Assessor schemes working in their area and this had led to positive results in reducing this time.

Q12 To what extent, if at all, do you agree with the statements below:

200 responses

More than half of respondents (55%) disagreed that the handover process and/or discharge paperwork demonstrated knowledge of the person being supported. 59% of respondents disagreed that the hospital discharge process offers people as much choice about how and where they receive support as is realistically possible. 49% of respondents disagreed that they were able to contact the person before they left hospital. Two thirds (68%) of respondents disagreed that they were included as equal partners in the assessments undertaken throughout the process. 47% of respondents disagreed that unpaid carers were included in the discharge and had the information that they needed.

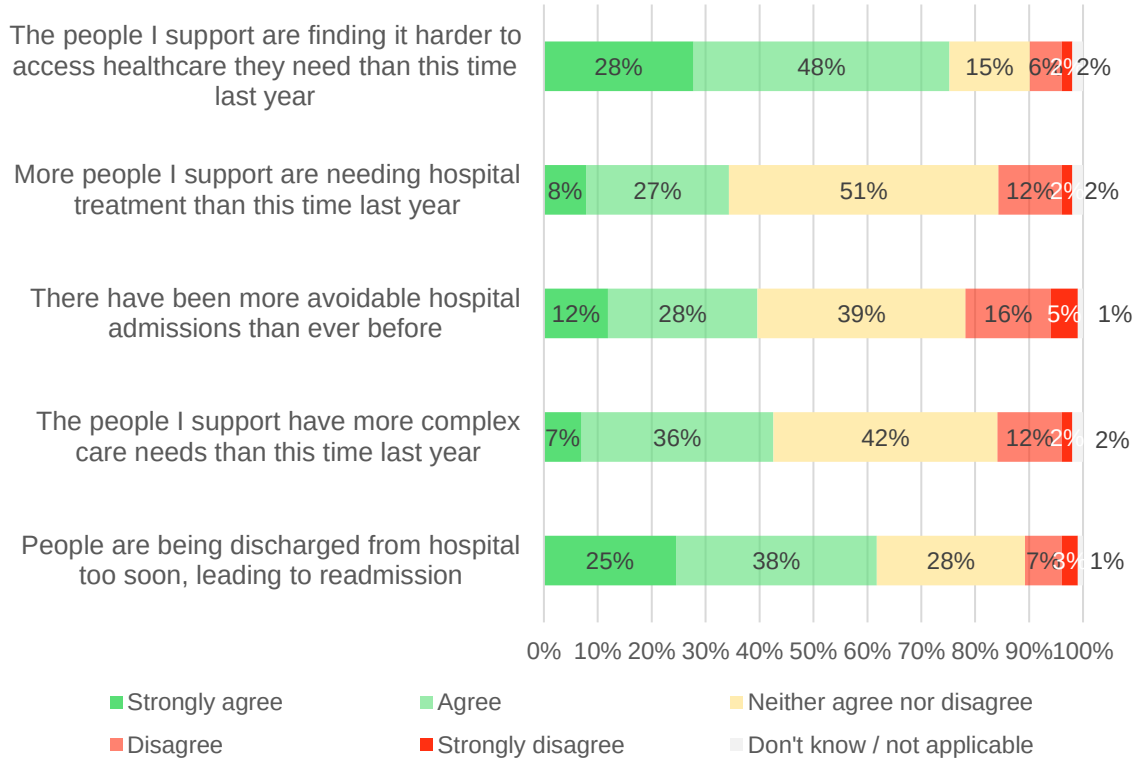


We included the question about choice twice in error, with minor variations in responses. So, we present the average between the two responses as the result.

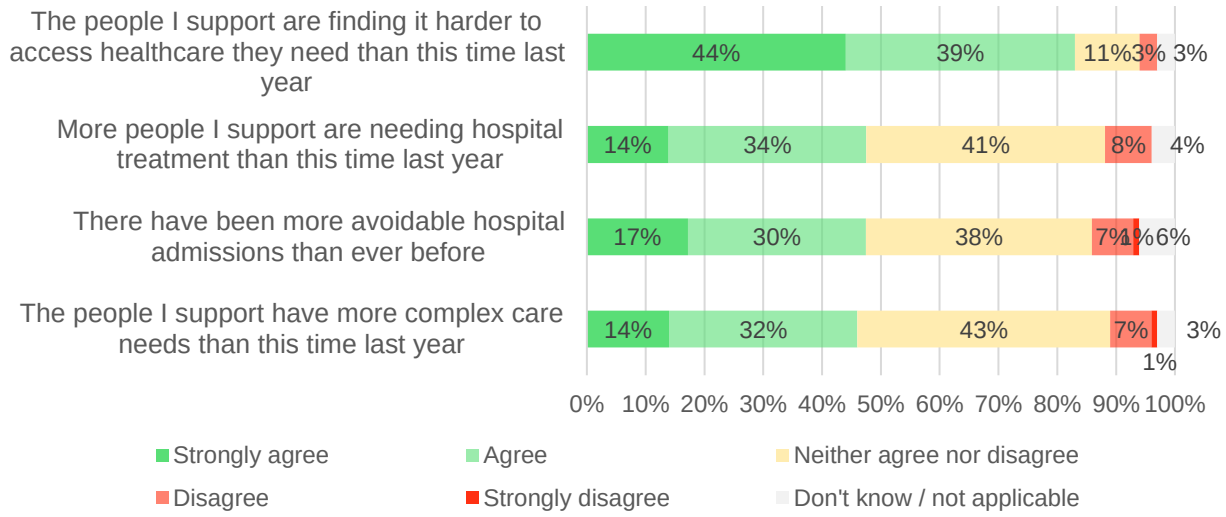
Q13 To what extent, if at all, do you agree with the statements below, when thinking about the people you support?

200 responses

Three quarters (76%) of respondents said that they agreed that the people they support are finding it harder to access healthcare than this time last year. A third (35%) of respondents agreed that more of the people that they support are needing hospital treatment than this time last year. 40% of respondents agreed that there have been more avoidable hospital admissions than ever before. 43% respondents agreed that the people they support have more complex needs than this time last year. 63% of respondents agreed that people were being discharged from hospital too soon, leading to readmission.



We asked similar questions in our Care Provision and Workforce survey in early 2023, which had a slightly stronger response; though it is unclear whether this indicates a slight improvement.



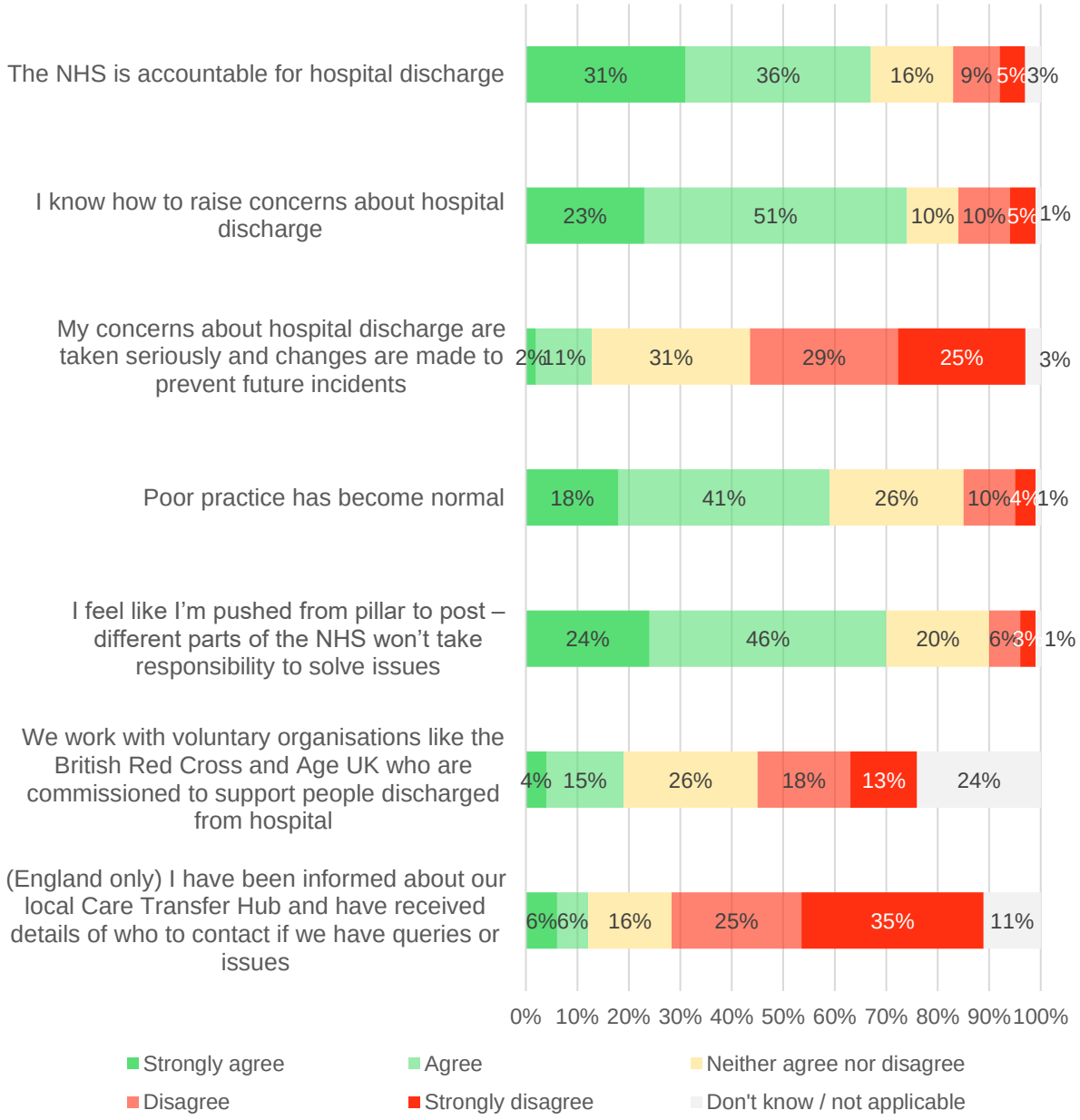
Q14 To what extent, if at all, do you agree or disagree with the statements below?

196 responses

Two thirds of respondents (67%) agreed that the NHS is accountable for hospital discharge. Three-quarters (74%) agreed that they knew how to raise concerns about hospital discharge. However, more than half (54%) said that they disagreed that their concerns were taken seriously, and changes made to prevent future incidents. 59% of respondents agreed that poor practice has become normal. 70% agreed that they felt like they were pushed from pillar to post, and different parts of the NHS would not take responsibility to solve issues.

There was a mixture of responses about voluntary organisations – 19% of respondents said that they worked with voluntary organisations like the British Red Cross and Age UK and 31% said that they didn't.

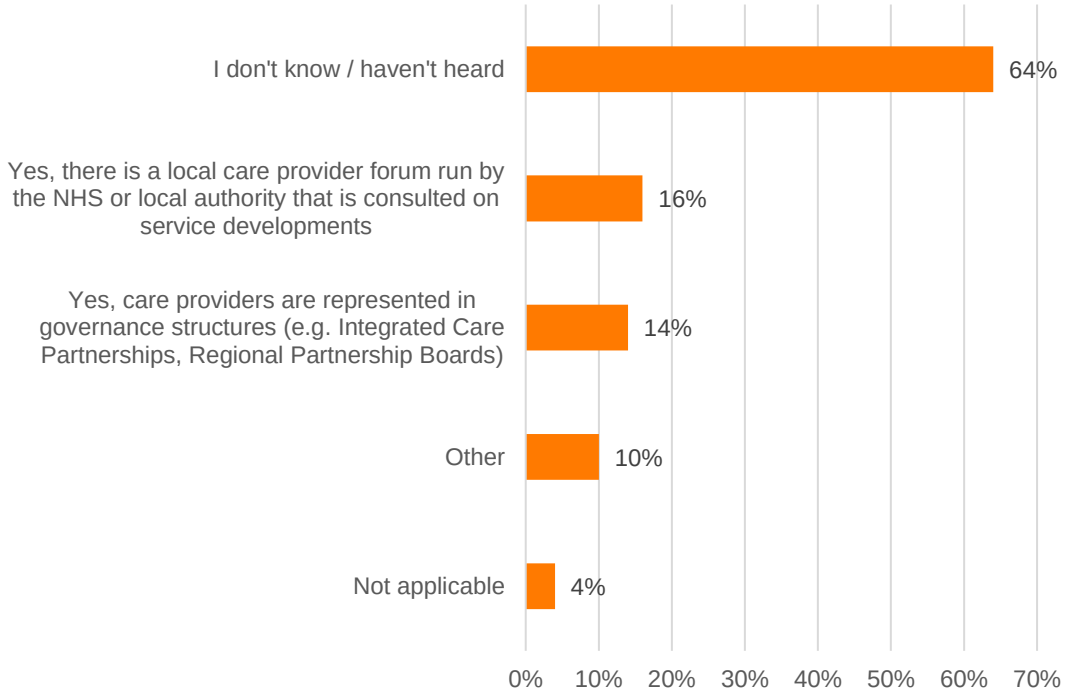
60% of respondents disagreed that they had been informed about their local Care Transfer Hub and had received details of who to contact if they had queries or issues.


The NHS is accountable for hospital discharge
31%
36%
16%
9%
5%
3%
I know how to raise concerns about hospital discharge
23%
51%
10%
10%
5%
1%
My concerns about hospital discharge are taken seriously and changes are made to prevent future incidents
2%
11%
31%
29%
25%
3%
Poor practice has become normal
18%
41%
26%
10%
4%
1%
I feel like I'm pushed from pillar to post – different parts of the NHS won't take responsibility to solve issues
24%
46%
20%
6%
3%
1%
We work with voluntary organisations like the British Red Cross and Age UK who are commissioned to support people discharged from hospital
4%
15%
26%
18%
13%
24%
(England only) I have been informed about our local Care Transfer Hub and have received details of who to contact if we have queries or issues
6%
6%
16%
25%
35%
11%
0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%
Strongly agree
Agree
Neither agree nor disagree
Disagree
Strongly disagree
Don't know / not applicable

Q15 To the best of your knowledge, are care providers in your area involved in strategic decisions about planning health services?

192 responses

Most respondents (64%) did not know or hadn't heard about how care providers were involved in strategic decisions about planning health services in their area. 16% knew of a local care provider forum; 14% knew care providers were represented in governance structures.



We received 19 'other' responses.

Some people thought that only specific parts of the social care sector were involved in the ICS. This includes residential care and short-term care for reablement.

Some respondents were national providers that engaged in other ways.

Some felt frustrated by their lack of engagement or being ignored. Some believed ICSs prioritise healthcare.

Q16 What could the NHS learn from social care around hospital stays and discharge?

146 responses

Some key themes emerged:

Understanding social care

Respondents stressed the need for NHS staff to grasp the concept, abilities, and structure of homecare. They said, “Too many hospital-based staff have no experience or understanding of community care, its benefits and challenges.” Respondents suggested NHS staff should spend time with providers. They hoped a better understanding of homecare would prevent some problems experienced now. These include unrealistic expectations about what care staff can do to support rehabilitation or delegated healthcare tasks, without discussion about training, capacity or funding.

If NHS staff don’t understand social care and the role of homecare staff, they may not give patients the right information on discharge.

Engaging social care

People felt that having open conversations with care providers about needs, what funding is available, and any issues is key. NHS commissioners were not always aware of care options, including live-in care, and what capacity was available in the system. Care providers want NHS colleagues to engage with them: “Involve care providers more in the entire process as partners.”

Respondents said hospitals do not always pay attention to feedback on mistakes: “they need to listen, be accountable, not allow unsafe discharge complaints to disappear”.

Providers mentioned HealthWatch **–** focus groups with Registered Managers were tried in Yorkshire.

Unmet costs

Providers raised concerns about the NHS creating costs that weren’t met; for example, cancelling a discharge at short notice or not arriving on time. This means careworkers have to work additional hours without the organisation being paid for it.

Respondents also highlighted late payments to providers.

People raised concerns that the NHS sometimes purchases care at the lowest price possible. This can create hidden costs through poor quality care. Responsible providers struggle to compete at low fee rates and may exit the sector. Low fee rates also make it hard to offer careworkers pay and terms and conditions of employment equivalent to NHS staff of a similar skill level.

One provider raised a concern about intermediaries being contracted to arrange hospital discharge.

Respondents also emphasised the need for joint budgets and person-led approaches: “There should be joint budgets for discharges instead of fighting for who pays for what. The client is not the priority for discharge, it’s the cost that always comes first.”

Awareness of people’s environment and baseline

Some providers praised social care’s ability to know and value the voices of those drawing on services.

Some respondents said NHS staff didn’t always speak to careworkers to understand what is normal for a person. One provider said they’d seen a case where the “hospital assumes patient has Dementia and sends home again. Patient has full capacity; this information would be able to be given by the home care provider and the hospital would know that this confusion is not normal”.

Discharge decisions sometimes fail to consider the home environment of the person being discharged. “A recent example included a lady who had been discharged to a very cluttered home alone, she had no way of getting to her bed and therefore was sleeping sitting up on her sofa, she had no food in the house and her boiler was condemned 24 hours after discharging due to high Carbon monoxide emissions. No one had discussed her discharge with her, and no one had checked/ asked her about her home environment. When we raised this as a safeguarding concern the safeguarding officer asked us what they should do about it”.

Prevention

Providers seemed keen to engage with the NHS about the preventative agenda, including:

- Looking at new ways to prevent hospital admission, for example, stepping up care to look after people at home when they have infections.
- Offering more rapid response services to prevent hospital admission; and greater focus on rehabilitation and avoidance of readmission following a hospital stay.
- Allowing care providers greater ability to refer people into the NHS for preventative support.
- “Don’t wait for a crisis before asking for help. Social care should be perceived as an enabling service, not a fallback when you can’t be independent.”

Some respondents were concerned about avoidable deterioration in people's condition whilst in hospital, for example, reduction in mobility and development of pressure sores.

Communication at discharge

A lack of information from hospital staff about people's needs, such as moving and handling, medication, and equipment, creates risk. Poor internal communication is also a problem. One provider said district nurses contacted them for information. Some people discharged from hospital needed continence services but did not receive referrals. The net effect can be to apply more pressure on the care provider to sort things out.

If care providers try to stay in touch with a person they support whilst they are in hospital, they may receive very little information, which frustrates them. Discharging patients without enough notice can damage relationships between hospitals and providers.

Training of staff

A couple of providers voiced concerns that ambulance staff, who brought people home from the hospital, lacked training in using hoists. As a result, they might leave people in a chair instead of assisting them in getting settled in bed. This required coordination because care staff who could use hoists had to be present to meet the ambulance staff.

One provider also raised a concern about discharging people in the middle of the night.

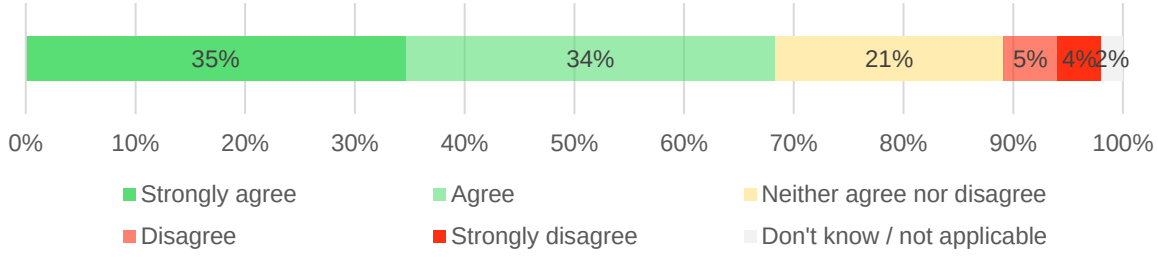
Assessment

A few respondents mentioned the importance of assessing people in their own homes accurately to gauge their capabilities.

Q17 Would you like to work collaboratively with other care providers in your area?

195 responses

Two thirds of respondents (69%) agreed that they would like to work collaboratively with other care providers in their area.



Q18 If you already do, please give details:

37 responses.

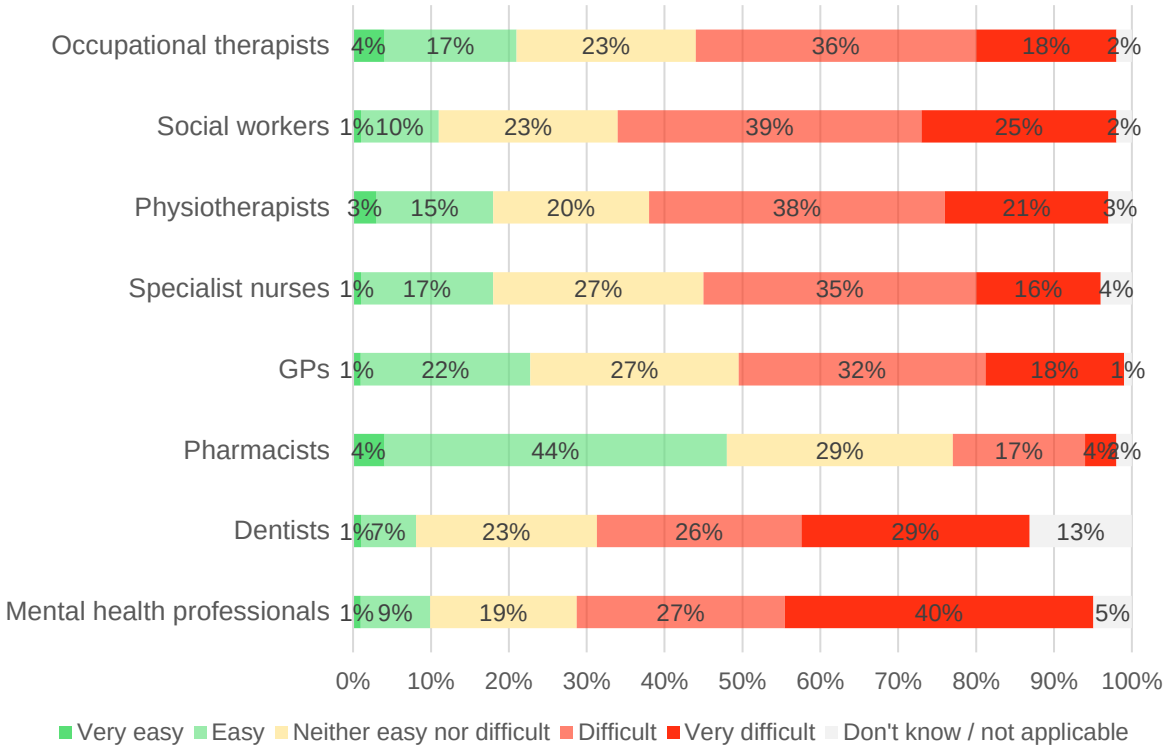
Many responses mentioned collaboration with other providers in local care associations, forums, and networks. These could present significant opportunities to collaborate, discuss common issues, and share successful approaches. Some providers were working with the charity and voluntary sector to improve services.

A handful of responses suggested providers were delivering joint care packages. However, difficulties with this kind of arrangement included confidence in quality standards and managing insurance liabilities. In one case, a respondent said that they were the lead provider for a geographic area.

Q19 How easy is it for the people you support coming out of hospital to get access to in person support from the following professionals they need?

196 responses

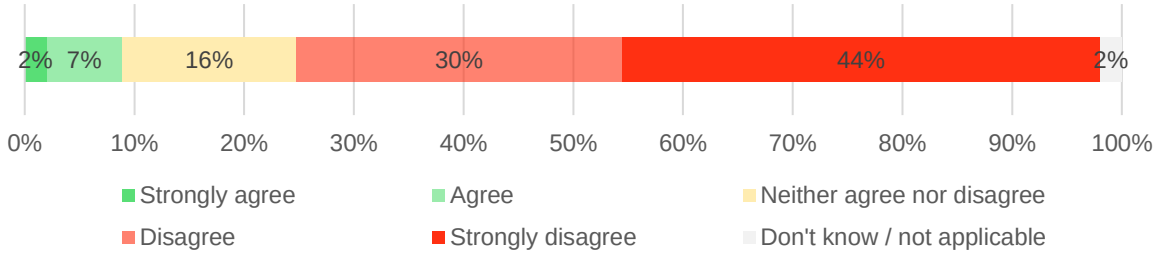
54% of respondents said that it was difficult or very difficult for the people they supported coming out of hospital to get the support they needed from occupational therapists. 64% said it was difficult or very difficult to get the support that they needed from social workers; 59% from physiotherapists; 51% from specialist nurses; 50% from GPs, 21% from pharmacists; 55% from dentists and 67% from mental health professionals.


Occupational therapists
4%
17%
23%
36%
18%
2%
Social workers
1%
10%
23%
39%
25%
2%
Physiotherapists
3%
15%
20%
38%
21%
3%
Specialist nurses
1%
17%
27%
35%
16%
4%
GPs
1%
22%
27%
32%
18%
1%
Pharmacists
4%
44%
29%
17%
4%
2%
Dentists
1%
7%
23%
26%
29%
13%
Mental health professionals
1%
9%
19%
27%
40%
5%
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%
Very easy
Easy
Neither easy nor difficult
Difficult
Very difficult
Don't know / not applicable

Q20 Do you feel that online support, where offered by professionals (e.g. by social workers), is as effective as in person support?

196 responses

Three-quarters of respondents (74%) said that they disagreed that online support was as effective as in person support.



Q21 Would you like to say more about online professional support?

One of the primary concerns raised about online professional support was that it affects the quality of assessments. A person might intentionally or unintentionally mask their symptoms when talking to someone who is assessing them on a computer, and it is harder to pick up on subtle cues via a screen.

Online contact could benefit some in simpler situations but may not work for everyone. Certain individuals suffer more from lack of face-to-face interactions. These include people whose first language is not English; older people who aren't used to using computers; and some people with mental health difficulties. Meeting professionals in person can be beneficial for people's mental health in certain situations.

Some older people have difficulty accessing online services (as well as participating in calls when they have accessed them).

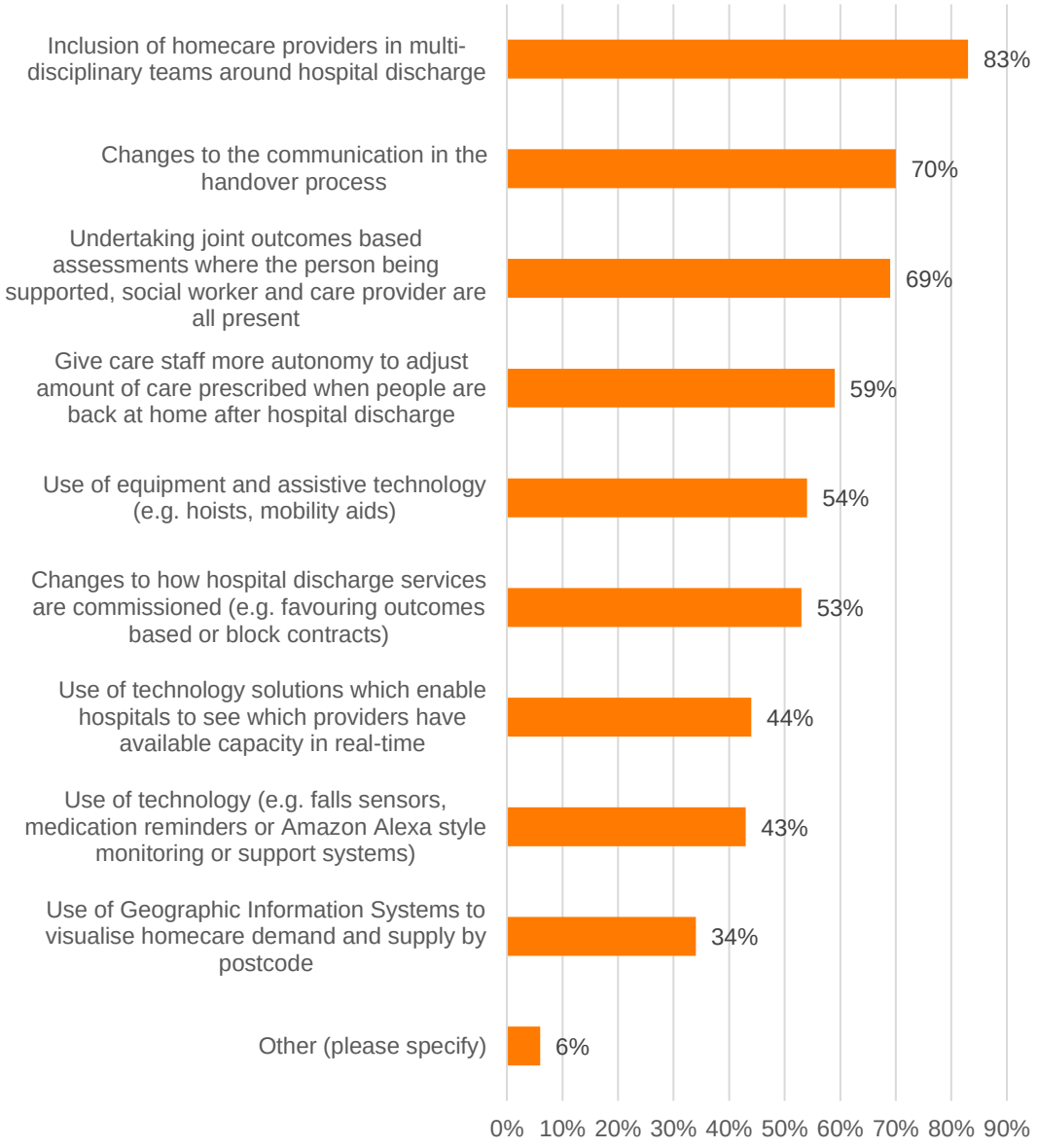
In one case there was a concern that some clinical tasks were being managed online that were inappropriate (with an older person being taught to inject themselves via video call).

Some respondents were not aware of online support being offered. And general complaints surfaced about professionals taking too long to respond.

Q22 Which of the following do you think could improve hospital discharge?

199 responses

The top three responses selected were inclusion of homecare providers in multi-disciplinary teams around hospital discharge (83%); changes to the communication in the handover process (70%); and undertaking joint outcomes-based assessments where the person being supported, social worker and care provider are all present (69%).



Q23 What opportunities do you believe there are to improve hospital discharge?

104 responses

Many respondents mentioned the importance of improved communication in various areas and situations.

- Discussing capacity needs with providers can improve planning.
- Discover providers' capacity by speaking with them.
- Seek care providers input – into assessments, planning, etc. Where appropriate, ICBs should resource care providers to take part in Multi-Disciplinary Teams (MDTs).

- Better handovers - this includes allowing care providers to attend discharge meetings. Hospitals must provide relevant information, such as health issues and support needs at nighttime.

- IT solutions - central systems which allow sharing of core information and an ability to see answers to questions. Different NHS staff members sometimes give contradictory information.

- Better internal NHS communication between different health professionals.

- More notice of discharge plans would be beneficial as well as more communication with people when they are in hospital.

Providers stressed the need to stay focused on the person and offer genuine choice regarding their discharge options. This includes considering “the whole picture - not just headlines and rates” and providing “better options for people to choose decent care. Discharge staff should follow up to ensure the care is meeting needs.

Price often took priority over care quality and outcomes, raising concerns. Some respondents raised use of micro-providers as a concern. They expressed concerns that inferior quality of care could cause repeated readmissions and lead to higher costs. “Care providers should be judged on results not the cost per hour.”

Other points raised included:

- Assessment – the desire to be more involved in assessments, the use of discharge to assess and appropriate assessment taking place.

- Planning – the need to address planning issues with transport, medication and equipment.

- Training – the need for discharge teams to understand how social care works.

- Funding – the need for funding to be adequate to cover competitive pay offers so good careworkers can be retained in the sector.

- Guidance – the desire for clear guidance and standards.

- Delegated healthcare tasks: “Upskill care companies to take on extra tasks but ensure there is correct insurance or payment for this.”

- Multi-disciplinary teams – the desire to take part in MDTs, with resources.

- Prevention – the suggestion that care teams could be contracted to help to prevent hospital admissions and also that people who are at higher risk of readmission (for example, people with diabetes) receive targeted additional support from social care.

- Transparent financial assessments – there was a concern that hospitals may discharge people without financial assessment.

Respondents presented different views on how to best organise care. For example, one provider suggested commissioners should offer work to more companies. Another suggested block-purchase of care rather than buying care by the minute: "Use the blocks wisely and they are much more cost effective and efficient."

Q24 Is there anything else you would like to say about hospital discharge?

74 responses

We received comments on the following themes.

Person-led care

Providers want to see people consulted properly; unpaid carers to be engaged; and good quality assessments. Some respondents were worried that cost pressures and contracts were causing unfair outcomes for those who need support.

- "We get the impression that it is get them out quick we need the bed."

- "Several of our clients have recently been put into care homes after being in hospital even though they have made it clear they want to go back to their own home. I truly believe that our clients are going to care homes because it is less work for the admin teams."

- "Allow patients to return to existing provider if they are happy, not try to make them move due to filling up capacity for contracted providers".

Partnership in Systems

Some respondents were worried because they have to raise concerns about hospital discharges frequently. Hospitals do not always communicate the outcome of complaint or safeguarding investigations. Providers want to see accountability of responsible managers.

- "Spend more and more time reporting to safeguarding boards regarding 'unsafe' discharges now than ever before".

- "We are seeing more and more unsafe hospital discharges and despite submitting safeguarding referrals, we rarely hear what the outcome of our concern is".

The situation has an emotional toll on staff: "*If you spoke with the team, we have in place who support discharges they would tell stories that most people would find very distressing".*

Providers want to be included in MDTs and assessments.

There were also concerns about parity of esteem between the health and social care sectors: "we need to raise the status of Carers (more money being major) in recognition of the important role they play in the whole process of keeping people living safely at home with the right support. There should be more recognition for unpaid Carers".

One respondent commented they were concerned about conflicts of interest. Another said they were "frustrated by the repeated headlines that our local hospital… are in crisis and struggling with patient discharge when they persistently ignore offers of support".

Safety and coordination

Respondents highlighted the importance of an effective handover process. Providers stressed the need for hospitals to share important health information, even if reluctant, and to communicate promptly with GPs.

Ensuring access to and coordination of equipment, medication and continence products was a challenge. This must be in place upon discharge. Hospitals should provide patients with one to two weeks' worth of products or medication to allow time to access them in the community.

Concerns arose about people being discharged without proper care and attention in certain cases: *"the client still had a cannula in her arm! Not the first time".*

Correct assessments are crucial. Respondents mentioned that hospitals sometimes discharge patients with a single-handed call when they need a double-handed call (i.e. two care workers per visit), causing difficulties.

These factors made providers uncertain and distrustful of the information provided:

- "Nothing is ever as it seems with Hospital discharges- we have been forced to expect the unexpected and are forced to scrabble around to get services in the community to support people who haven't been adequately assessed prior to discharge".

- "In many cases, an individual's abilities have been exaggerated to the extent of becoming fiction…Discharge teams are clearly under

pressure to create space but seem to forget they have a duty of care to their existing patients as well."

Can we organise care to support hospital discharge better?

Again, respondents were concerned that care was being commissioned based on price without regard to quality. Discharge teams may not have a full understanding of the capacity of the homecare sector in their area: *"no patient need be a delayed discharge - there is enough capacity in the system if every provider is involved - so many companies are ignored, and massive capacity is wasted."*

There could be better training and support for discharge teams to help them understand the sector.

There was also a suggestion that current practice was too task focused and that communications need to improve to have success in delivering the outcomes.

Providers raised concerns about the NHS not paying for failed discharges, as they allocated careworker time to that work. Late payments were also an issue.

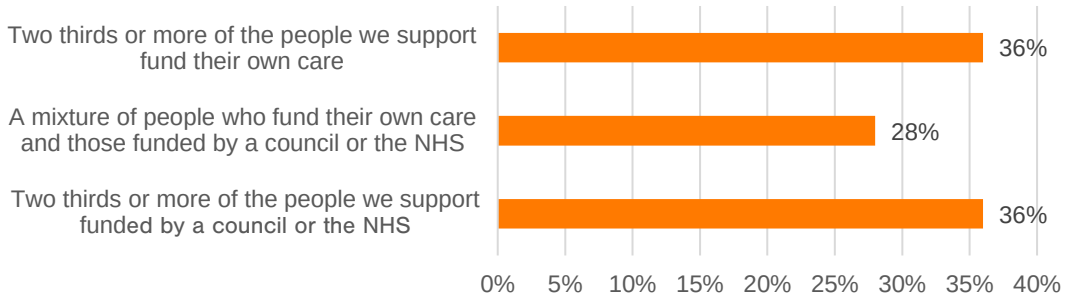
- "Payment for service is very slow and unnecessarily complex."
- "Costing of a service must include overall service responsiveness, continuity of care so clients don't go back into hospital, pricing to include care worker salaries, investment in their training, salary and wellbeing support."

Other

One provider commented that *"It is IMPOSSIBLE to get dental assistance for housebound clients".*

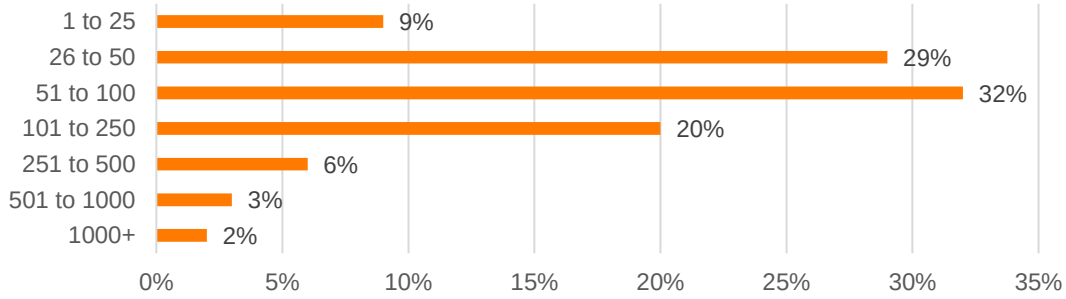
Q25 Thinking about the people you support, which of the following best applies? (Select one)

199 responses



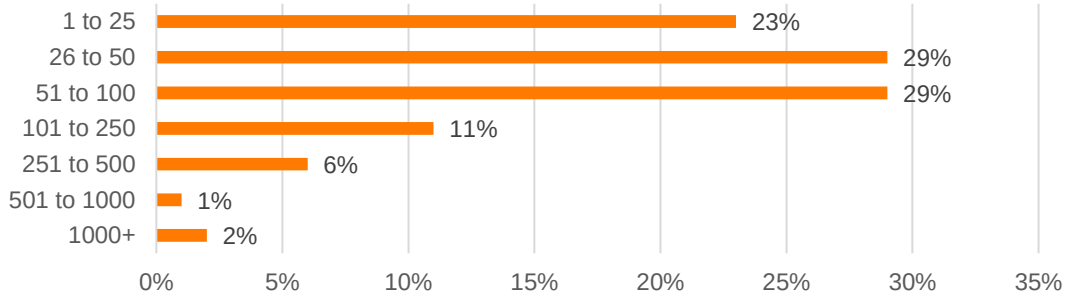
Q26 How many people do you support?

197 responses



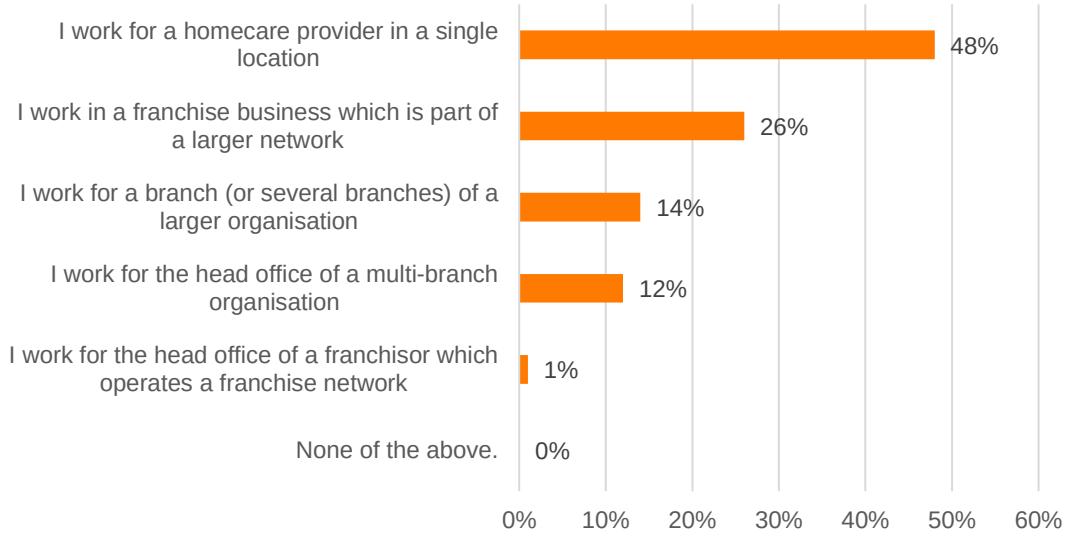
Q27 How many careworkers do you have?

197 responses



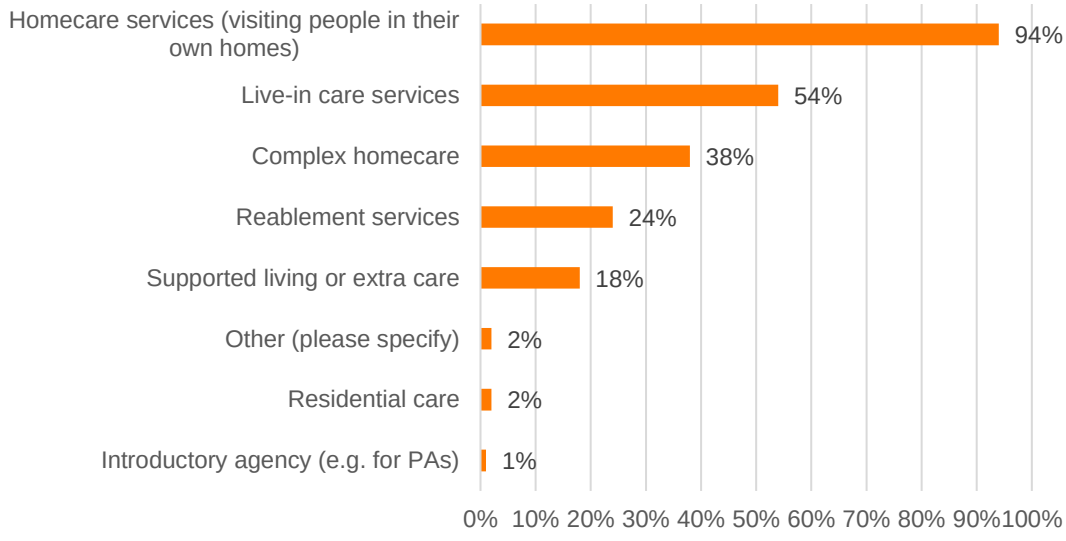
Q28 Which of the following best describes your role in the organisation you work for? (Select one)

198 responses



Q29 What types of care do you provide? (select all that apply)

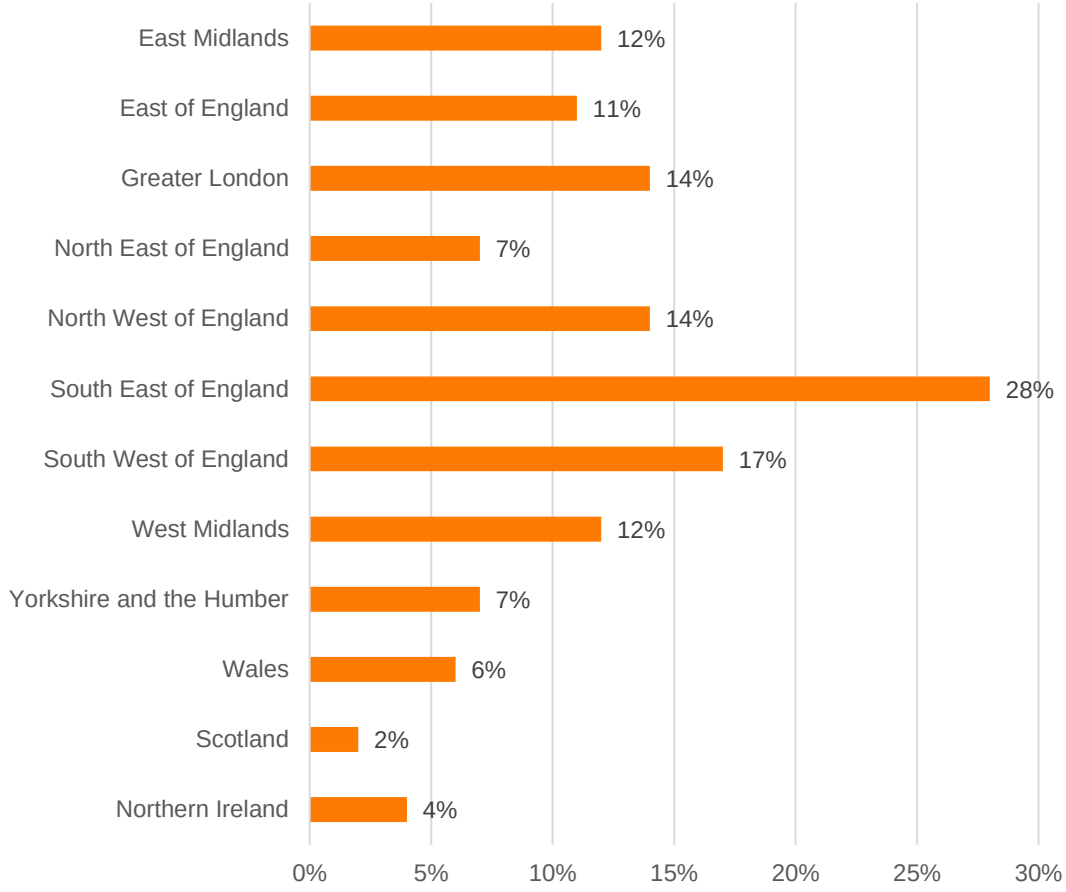
198 responses



‘Other’ included Hospital Discharge under Community Recovery Service; intensive reablement; palliative care and live-in nursing care.

Q30 Which of the following best describes the location of the branches or franchises of the organisation that you are responsible for? (Tick all that apply)

198 responses

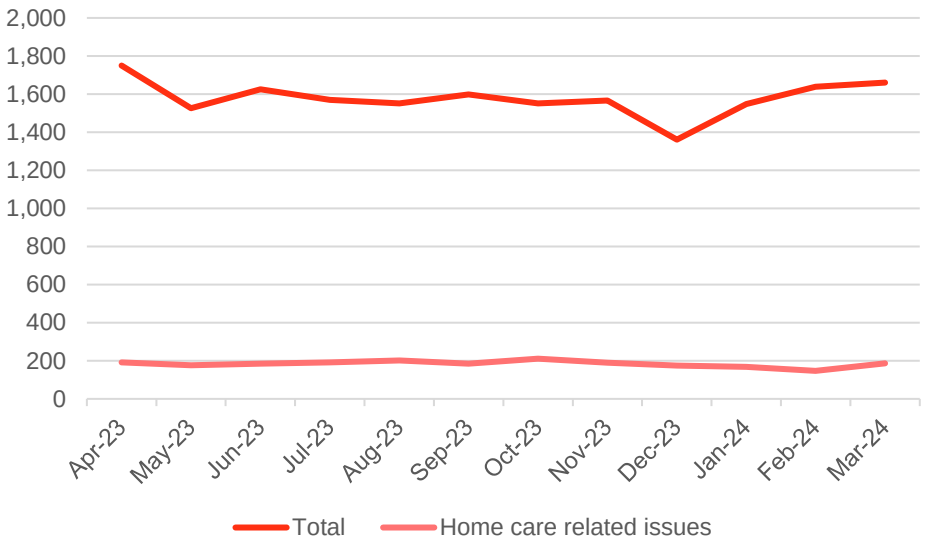


Appendix B – Devolved nations

Wales

Recent delays in transfer of care in Wales have been constant, with homecare related issues accounting for around 200 delays a month across the country.

Pathway of Care Delays by reason for delay and date (Wales)
(Source: Pathway of Care Delays by reason for delay and date (gov.wales))



The Senedd's Health and Social Care Committee's reported on *Hospital discharge and its impact on patient flow through hospitals* in June 2022. The Committee identified issues in the supply of homecare relating to staffing shortages. This included concerns that people were being discharged to care homes because of a lack of homecare. The Committee called for the Welsh Government to explain how it would increase recruitment into the sector. It also called for an update on the work of the Social Care Fair Work forum in Wales around the lack of sick pay for careworkers.

Other issues raised by our members were also evident in this report. For example, the National Pharmacy Association gave evidence to the Senedd that said, "when changes were made to patients' medication during emergency admission to hospital, almost a third of patients were readmitted within two weeks of discharge as they had reverted to pre-admission medication because repeat prescriptions were not amended" (p.57).

At points the situation has led to public appeals. In August 2022 the Health Board in North Wales encouraged family members to support their relatives out of hospital, on a short-term basis, whilst waiting for homecare capacity because the capacity situation in the hospitals was serious.

Other policy initiatives undertaken in recent years or underway include:

- Regional Partnership Boards in Wales have some shared funding to facilitate the Integration of Health and Social Care; which includes consideration of hospital discharge amongst other things. This includes the Integrated Care Fund, as well as some one-off specific funding (e.g. around winter discharges).

- In July 2022, as part of the "Six Goals for Urgent and Emergency Care" work the Minister for Health and Social Services set Local Health Boards the challenge of creating an additional 1000 "beds" capacity for hospital discharge across Wales. Homecare providers were assured at the time that this was not necessarily in intermediate care, care home or other residential facilities, and could be as equivalent support for a person in their own home.

- The Further Faster programme is looking to reduce pressure on hospitals through strengthening community services including expanding NHS community teams and expanding reablement services. As part of this workstream the Welsh Government is considering how to develop their domiciliary care strategy.

- The Discharge to Recover and Assess (D2RA) programme (similar to the English Discharge to Assess (D2A)) has been implemented but what actions are being progressed will vary across Wales.

- In 2022 there was a 'system reset' looking at patient flow issues.

- Having recently refreshed the data set available, work is underway on improving hospital discharge in Wales, including through looking at the role assessments play in the process.

- Updated guidance for hospital discharge was issued in December 2023.

Interview and survey feedback

Although the sample size for Wales was too small for accurate quantitative results, we received feedback from providers in Wales.

Broadly speaking, the issues that providers were most concerned about across the UK were also being reported by Welsh providers. Communication from hospital teams with providers was felt to be key to improving the situation.

Some of our interviewees expressed frustration about the '1000 beds' fund. Although there were assurances that this did not necessarily mean residential beds, providers in some parts of the country felt the emphasis was on using care homes to relieve hospital pressures. Some care home beds commissioned through this were understood to have been under-used.

To give a flavour of feedback from Welsh providers:

> *"Hospital discharge is shocking in south Wales resulting in safeguarding concerns being raised regularly for unsafe discharges."*
>
> *"Hospital are under pressure for beds but sending people out too early without or wrong medication or no manual handling equipment only leads to re admission very quickly."*
>
> *"Hospital discharges have become like damage limitation. People are discharged without the correct equipment, medicines, support. Often discharged claiming to be single handed, when we arrive, they are double handed with nothing in place. Discharge planning is poor, care providers are not contacted to attend MDTs where their views should be sought. Minimal information is shared on care plans. We spend more and more time reporting to safeguarding boards regarding 'unsafe' discharges now than ever before."*
>
> *"Allow providers to make care needs assessments - why do social workers only do this; providers are far better at it."*

Scotland

In 2019, the Scottish Government provided guidance on discharge planning. The aim was to reduce the number of people waiting to move from hospital wards to their homes or different care. They created a separate document about involving carers in discharge planning, stating:

> *"If care is planned without the input of the carer, an opportunity has been lost. Therefore, engagement and co-operation with carers is an essential part of good patient care. Furthermore, co-operation is needed from carers to effectively implement any future care plan. Involving the carer when devising a care plan, and listening to the carer's views, is likely to result in better outcomes for the patient and carer."*

During the early months of the COVID-19 pandemic, there was a concerted effort by the Scottish Government for staff to make available hospital beds, given the rate of infection. Monthly figures published by Public Health Scotland (PHS) showed in March 2020 the average number of beds occupied (per day) due to delayed discharge was 1452, compared to just 676 in April 2020. This 53% decrease was because of infection control measures put into place.

Almost two years later, the landscape had not improved, with an (on average) 51% increase in the number of beds being occupied by delayed discharge. 63% of which were experienced by those aged 75 years and older. Variation did occur, with the City of Edinburgh and South Ayrshire local authorities registering the highest number of delayed discharge days. 35% of delays were due to awaiting the completion of care arrangements.

A review of the Adult Social Care system in Scotland was led by Derek Feeley, former Scottish Government Director General for Health and Social Care and Chief Executive of NHS Scotland. The government released the report in November 2020 after investigating and consulting with different groups. The report suggested that people view care homes as the default option but would prefer to live in their homes for as long as they could. Mr Feeley said: “moving into a care home must always be the informed choice of the person requiring care and support”. He advised the government to find new ways to support care at home, rather than focusing on building more care homes. Recommendations made a strong case for a National Care Service (NCS).

Facing considerable pressures on hospitals in the winter of 2021, the Scottish Government provided £60 million in grant funding so people could temporarily move to a care home until their homecare package was ready. This same funding package also allocated up to £48 million to increase the hourly wage of social care staff to match that of NHS staff Band 2.

The National Care Service Bill was introduced in June 2022, beginning the legislative process to create a National Care Service. This outlined the creation of Care Boards, replacing Integrated Joint Boards (IJBs), to administer NHS primary and Community health provision alongside social care.

The bill was met with resistance from unions and opposition MSPs. Almost two years later, the bill has been delayed 4 times, due to budget cuts, concerns raised by several committees, and changes in leadership. The Bill is currently at Stage 2 and undergoing amendments.

Neil Gray MSP was named the new Cabinet Secretary for Health and Social Care after the resignation of Michael Matheson in February 2024. Upon his appointment to the cabinet, he affirmed: “We are committed to delivering a health and social care system that works for the people of Scotland.”

This commitment requires significant government support. Figures in March 2024 show the average number of beds occupied by delayed discharge is 1,892, a three-month high. And a 9% increase from March 2023.

More recently, over 20 charities and organisations, including Scottish Care and Age Scotland signed an open letter calling for the Minister to reinstate a Minister for Older People.

Following Hamza Yousaf's resignation in May 2024, John Swinney, the new First Minister, needs to provide support and funding to make sure everyone can access care.

Interview and survey feedback

The sample size for Scotland was too small to get reliable results. We did, however, receive feedback from providers there.

Workforce issues are prominent across the UK, and Scottish members supported this in our feedback. They were keen to point out that an uplift in fee rates would improve capacity and therefore increase the number of patients discharged from hospital. One member stated:

> *"If careworkers were offered the same terms and conditions as NHS under a fairly evaluated Agenda for Change role, more staff would be available in social care to help the system, both with preventative care and discharged."*

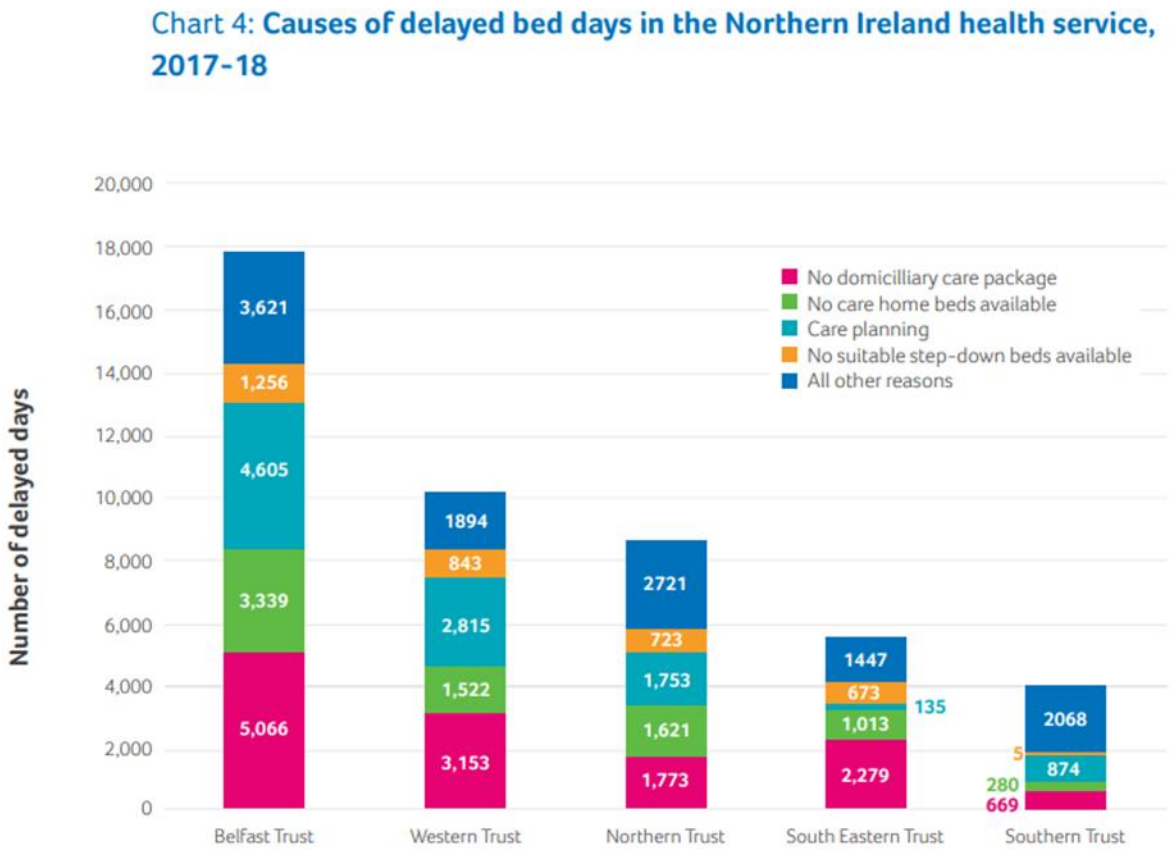
There was also frustration regarding the lack of communication and the access to communication channels between hospitals, providers, and other members of the multi-disciplinary teams involved in the discharge process.

Feedback from providers in Scotland also included:

- *"When we've got a planned discharge, quite often we'll try and coordinate with hospital transport so that we can have care practitioners in the person's home when they're dropped home from hospital. It never works out."*
- *"I can't stress this enough. You know, people come out of hospital without essential equipment. They might have barely moved from the bed the entire time that they're there, you know? So have they had a proper mobility assessment?"*
- *"Hospital discharges will only improve in numbers once social care capacity is improved."*

Northern Ireland

Marie Curie, a UK charity that focuses on end-of-life care, conducted research using Freedom of Information (FOI) requests. They found that over 200 people died in Northern Ireland in 2018 while waiting to leave the hospital. In their report, *Every minute matters*, they concluded that a shortage of domiciliary care was a significant reason for delayed discharge.



(Marie Curie, Every Minute Matters. Chart 4: Causes of delayed bed days in the Northern Ireland health service, 2017-18).

According to the report, low fees and a shortage of care workers, as well as funding from the Health and Social Care Trusts, affect the availability of care. In addition to addressing the fee rate and workforce issues identified, the report recommended developing special hospital to home palliative care planning teams in hospitals.

In January 2020 the British Red Cross published a report on hospital discharge in Northern Ireland: *Life Beyond the Ward*. The report discussed how hospitals are facing more pressure due to demographic changes. It also mentioned Marie Curie's research on the lack of care packages for people at home. Interviews by the Red Cross also highlighted issues with availability of social care packages and workforce. They also found that some people went home to unsuitable housing; did not understand their diagnosis; and received poor communication about their needs at discharge. Fall preventions teams and rehabilitation also needed to be resourced adequately. The report recommended that commissioners make use of the voluntary and community sector to support discharge; that they check people's ability to live independently as part of the discharge process and that adequate funding is available for community-based services.

The COVID-19 pandemic had a significant impact on hospital discharges in Northern Ireland. During the initial outbreak in early 2020, there was a sharp decline in

hospital admissions for non-COVID-19 reasons. Fear of getting the virus or overwhelming healthcare resources made people avoid seeking medical care. Additionally, staff shortages due to COVID-19 infections, quarantining, and redeployment of healthcare workers to COVID-19 wards affected the ability to discharge patients efficiently.

In the summer of 2022, the demand for care services continued to grow and the strain on hospitals was increasing. The Department of Health urged patients, their families and carers, to work together to help the discharge process and ensure patients did not stay in hospital longer than needed.

Amongst the urgent appeal they stated: *"If patients are deemed medically fit by the consultant/senior doctor to go home and are waiting on a care home placement, HSC Trust staff will allocate the first place that is suitable for you."*

The Department stated these measures would help to support hospital staff as the demand for hospital services was increasing. By December 2022, the Northern Ireland Health Trusts had agreed upon new targets for discharging people from hospital. Deeming that once patients were medically fit to be discharged, they would arrive either at home, or to other care settings, within 48 hours.

In October 2023, the Government published their plan to address upcoming winter pressures for 2023/2024. Health and Social Care Trusts were allocated recurrent funding of £697,000 to complete the establishment of early review teams. These teams will be responsible for the undergoing reassessments of need within two – eight weeks of discharge from hospital. Alongside this, a Social Care Collaborative Forum was formed, with a focus on enhancing weekend hospital discharge and reducing complex delayed discharge.

In March of this year, the recently reinstated Health Minister Robin Swann announced a support package of £70 million to stabilise organisations due to an increase to minimum wage. MLAs, Northern Ireland Trusts and social care organisations called for additional, long-term funding strategies to support the sector.

Figures showed that over 600 hospital beds were occupied by patients who were deemed medically fit for discharge on one day in March. Later that month, the Health Minister called on the Executive to address the funding gap, as he was "looking down the barrel of an inadequate budget for 2024/25, while also facing growing need and demand". He also stressed prioritising primary and social care. However, in May the Department of Health told an Oireachtas committee that spending across the health sector is more than £500 million over budget in the first four months of the year. With Department of Health Secretary General Robert Watt stating that around 75% of this amount is attributed to the acute hospital sector.

With an ageing population, the increase in complex care services and the amount of medically fit people remaining in hospital far longer than they need, more planning and funding must be allocated to the improvement of hospital discharge services across Northern Ireland.

Interview and survey feedback

Our data collection didn't have enough samples accurately to quantify findings, which is in line with other devolved nations. However, overall feedback from providers in Northern Ireland painted a more positive report of the discharge process, with acknowledgments to progress made during and after the COVID-19 pandemic.

Our respondents did, however, raise the need for Heath Trusts to continue to build on those improvements and ensure homecare is accessible for all.

Providers in Northern Ireland raised concerns about the limited availability of care services in rural areas, leading to longer travel times to reach clients in those regions.

More feedback from our members in Northern Ireland included:

- "*We don't do so much directly from the hospital, so I don't get a lot of calls from hospital discharge or short-term assessment teams wanting to place people. But I do get a lot of calls from families who have been in the system for a long time waiting for care, and they just can't get it for one reason or another."*
- *"Hospital discharge varies from Trust to Trust, but it only works well where you have core services in the area."*
- *"We have got to be able to track and retain more staff, and until all those circles are squared, I do not see a major change."*
- *"We are not nurses; we are not doctors... I think it's important to remember the definition of domestic care, and that is the care which a loving relative could otherwise provide. So, we must not allow ourselves, unless commissioned to do it, to stray into medical territory. We are not providing medical care. We are providing social care."*
- *"I don't think that there is a major issue in the actual operation between health and social care other than in terms of budgets. Because the health budget is one thing, social care budget and primary care budget is another."*

Shaping homecare together

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