# CARE CLOSER TO HOME

Llais Powys - 2025

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## Introduction

Many Powys residents are experiencing delays in being discharged from out-of-county hospitals despite being well enough to go home, due to delays such as waiting for home adaptations, care packages, or access to supported accommodation. These delays can worsen mental health, slow recovery, and lead to physical deconditioning. Timely discharge is essential for freeing up hospital resources and making use of local community services, which are often easier to access in rural areas such as Powys.

The Health & Care Strategy for Powys (to 2027 and beyond) refers to the desire to “provide as much health and care as possible in Powys”, “bringing care closer to home” and “we could do more in Powys”. However, delays in Occupational Therapy assessments, care packages, and care home placements are contributing to “bed blocking” and creating significant challenges in hospital discharges.

## Project Aims

Our goal is to identify the root causes of slow discharge processes for Powys residents in out-of-county hospitals. We aim to understand the challenges and opportunities to improve discharge processes, influence care closer to home, and provide policy recommendations to strengthen local services and improve patient outcomes.

## What we did

1. Reviewed all meeting, engagement & survey reports and pulled out all comments people have made which relate to care closer to home.

2. Reviewed Patient Experience Stories and Complaints data for examples which relate to care closer to home.

3. Obtained information from the Health Board and Powys County Council about the capacity of home care services, community support programs, and supported accommodation.

4. Met with relevant organisations to learn from their findings and gain a deeper understanding of the situation in Powys and what residents face when accessing care closer to home.

5. Used social media and local press to request members of the public come forward with their stories and experiences.

6. Identified leaders from underrepresented groups and have invited them to share with us their insights.

7. Visited two Powys care homes to gather patient feedback.

8. Visited the two Powys 'Ready to Go Home Units' (RTGHU) in Llanidloes and Bronllys to seek patient feedback about their experience of staying on the units.

# Key Findings

## Community Engagement - What we were told

### Delayed Care Packages and Social Care Support

Many Powys residents report significant delays in securing appropriate care packages and social worker assessments, which directly impact discharge timelines. The shortage of social workers and carers in rural areas has been cited as a primary factor.

For example:

• A patient from Llanidloes waited seven weeks for a care package, and they were unable to be discharged until social worker assessments had been completed despite being well enough to go home.

• In another case, a patient from Ystradfellte remained hospitalised for two months awaiting care provision, which led to a transition into a care home.

• A woman recovering from a fall had severe delays in receiving her care package, leaving her unable to manage personal care needs, causing significant physical and emotional strain.

### Delays in Home Adaptations

Delays in home adaptations are another significant factor contributing to prolonged hospital stays. Patients who require modifications to their living spaces, such as ramps, mobility aids, or bathroom adjustments, often face lengthy waiting times, preventing discharge.

For example:

• A patient from Rhayader with leg ulcers faced months of delays before home adaptations could be made, forcing them to stay in transitional care longer than necessary.

• An amputee waited six months for necessary bathroom modifications following an assessment, severely impacting their ability to live independently.

**Carer Availability and Social Services Shortages**

A recurring issue among patients and families is the lack of care support.

For example:

• One caregiver described how, due to minimal support from social services, they had to arrange for private care at their own expense, highlighting the financial burden on families.

• Rural communities in Powys, have reported struggles to secure care providers, leading families to shoulder care responsibilities themselves.

• Some patients experience a lack of continuity in care. For instance, in Brecon, a patient awaiting urgent follow-up care faced delays due to inconsistent caregivers and unclear post-hospital timelines.

**Communication**

Breakdown of communications between hospitals, social services, and patients has been identified as a key cause of discharge delays. Patients have also reported difficulty reaching social services to arrange post-discharge care, contributing to confusion and frustration.

**Inconsistent Care and Lack of Continuity**

The lack of continuity in care, and administrative challenges have resulted in prolonged hospital stays and disrupted care.

For example:

• A case from Glan Irfon highlighted how patients experienced multiple transfers between wards and hospitals, resulting in muscle deterioration due to a lack of continuity and the emotional toll of uncertainty around discharge timelines.

• A similar situation in a care home was reported where the patient struggled to adjust due to varying care levels and inconsistent caregivers.

**Financial Strain**

Financial constraints influence delays in discharge. Several families reported having to fund essential care services out-of-pocket due to gaps in social services support.

For example:

One family carer described paying £400 per month for supplies not covered by social services, while others spoke about the challenge of arranging private care due to the lack of publicly funded options.

# Service Providers - What we were told

### Miscommunication and Lack of Staff Involvement

Feedback highlights concerns about Multi-Disciplinary Team (MDT) meetings, where senior team members make decisions without engaging frontline staff. This lack of communication creates a disconnect between planning and on-the-ground care delivery.

### Inappropriate Placement Decisions

Patients are reportedly placed in RTGH units based on desk-based decisions rather than clinical need, leading to unsuitable placements and repeat hospital admissions.

### Workforce Shortages and Skill Gaps

The reliance on younger, less experienced social workers — driven by cost-saving measures — has contributed to poor decision-making and high sickness rates. We have had reports of no social worker presence for over a year in one Mid-Powys medical practice.

### Limited Capacity in Social Care Services

Despite a transformation program increasing home care capacity by 2,000 hours per week over the last 12 months, waiting lists persist due to financial pressures for providers (in particular the rise in employers NI contributions, the rise in fuel costs and the real living wages increases), unfavourable demographics between working age individuals and individuals in receipt or waiting for home care, and a negative perception of the care profession.

**Geographic Barriers**

Rurality significantly impacts care delivery. Care packages are refused when travel costs outweigh the provider's perceived value, leaving patients without support. Families also face increased travel times to visit loved ones transferred to distant facilities. In one scenario, we learned of a care package being refused in Crossgates by one provider due to the travel despite being just 3.2 miles from Llandrindod Wells.

**Disconnect Between Policy and Practice**

While Ready to Go Home units promote independence and timely discharge, providers have received reports of poor patient experiences, including inappropriate bracketing of needs and placements driven by bed availability rather than clinical suitability.

**Re-admissions**

We had reports of some patients being discharged with unsuitable care packages and so were subsequently readmitted. These patients when this happens are recorded as new admissions, which will potentially result in data gaps in the true scale of delayed discharges.

**End-of-Life Care Challenges**

Patients nearing end-of-life are often admitted due to a lack of domiciliary care. Carers face emotional strain, and younger, less experienced carers may rush visits (fear of the condition and appearance of a person receiving end-of-life care), reducing quality of care and leaving patients feeling isolated.

# Ready to Go Home Units - What we were told

When visiting the Llanidloes Hospital and Bronllys Hospital Ready to Go Home Units, we spoke to 15 patients and had discussions with staff. The units were almost at full capacity. We were given examples of some patients being discharged within a week. It was evident in both the Llanidloes and Bronllys Ready to Go Home Units, that they are meeting their objectives by providing a supportive, comfortable and less clinical environment that encourages independence for patients transitioning from hospital to home or care facilities. However, the recurring issue of **delays in care packages** represents a significant challenge that **hinders timely discharges.**

### Encouragement of Independence

Both units foster patient independence through activities and support for mobility, which many patients find beneficial for their recovery and well-being.

### External Care Provider Collaboration

Positive feedback was given regarding communication with external services (e.g., homecare agencies and community connectors) who were active in helping some patients with attempting to arrange care packages.

### Delays in Care Packages

In both units, delays in securing care packages were noted as a **key issue** that contributed to extended stays, with patients often **waiting longer than medically necessary.** This delay is a root cause of slow discharge and a common barrier to timely transitions.

**Physiotherapy Access**

Some patients mentioned inconsistent physiotherapy services, and felt the physiotherapy was not frequent or accessible enough to aid their recovery for quicker discharge.

## Recommendations

**Discharge Planning and Communication**

• Implement communication pathways between hospitals, social services, and community providers to prevent miscommunication.

• Develop a feedback loop with patients and families to continuously assess the effectiveness of discharge processes and care placements.

**Workforce Shortages and retention of staff**

• Develop targeted recruitment campaigns to attract social workers and care staff, emphasising the value and importance of the profession.

• Introduce financial incentives such as travel support to retain staff, in rural areas.

• Provide ongoing training and mentorship for younger, less experienced care workers to improve decision-making and the likelihood of sickness.

• Provide specialist training for care workers handling end-of-life cases to ensure compassionate and unrushed care.

**Home Adaptions**

• Consider building relationships with businesses at a local level to support quicker home adaptions. (Can contracts be agreed geographically?)

• Explore ways to establish a "fast-track" system for urgent home adaptations and care assessments to prevent unnecessary hospital stays, freeing up beds for those more in need.

**Enhance Support for Carers and Families**

• Provide financial and emotional support resources for family caregivers who step in due to service gaps. Read our report on Unpaid Carers for insights into what information would be beneficial.

• Explore developing training programmes for unpaid caregivers to ensure families feel confident providing interim care while waiting for care packages.

**Enhance Physiotherapy Provision**

• Improving access to regular physiotherapy sessions for patients on the Ready to Go Home Units will aid in patient independence and will reduce the risk of deconditioning.

**Address Geographic Inequities**

• Consider solutions to ensure rural care packages are not refused due to travel cost concerns

**Data**

• Ensure readmissions due to failed care packages are logged appropriately and used to identify recurring issues and areas for improvement.

## Next Steps

Based on what we heard, Llais Powys will:

• **Engagement & Advocacy:** Present findings to Powys Health Board, Powys County Council, and key stakeholders.

• **Resource Development:** Support service providers in creating accessible materials to service users about available services.

• **Continued Outreach:** Continue to engage with the public other organisations to expand engagement and gather community insight, with a focus on underrepresented and rural populations

By implementing these recommendations, we aim to improve the quality of care for service users across Powys.

If you would like to share your experience, please contact us at **01686 627632** or **powysenquiries@llaiscymru.org**.