



LLAIS GWENT - HEALTH & SOCIAL CARE SUMMIT

Hospital Discharge in Gwent:

Listening, Learning, Working Together

January 2026

What we did

Key stakeholders from across health and social care in Gwent came together to discuss hospital discharge delays and their impact on patients, families, carers, and staff. Together, we explored what delayed discharge currently looks and feels like for the people involved, and what improvements could be made across the system to achieve better outcomes. Participants shared their experiences through talks, videos, feedback, and open discussions, helping us build a clearer picture of what hospital discharge is like day to day.

What people told us

Main problems



What people told us

1. Integration between Mental Health, Learning Disabilities, Health & Social Care

- Discharge processes are described as slow, clunky, and disjointed, leading to disconnect when people are ready for discharge.
- Mental health teams are inconsistently involved across Gwent in wider discharge discussions.
- Physical health needs among mental health inpatients often complicate discharge planning, as assessments are completed in environments that do not represent people's normal lives.
- People told us that stronger partnership working is needed on Section 117, so relapse and readmission are reduced and people get the right support to stay well in the community.

2. Pressures on Nursing & Residential Placements

- People who are fit for discharge shouldn't be waiting in hospital, but delays in care packages, nursing and residential placements mean they often have no alternative.
- Out-of-area placements are becoming more common due to pressures on local nursing and residential provision.
- Difficulty sourcing appropriate placements, especially for people with complex needs.
- Housing solutions to support discharge are limited. People pointed to the previous best-practice model, 'In One Place' which demonstrated the impact of joint working between health, housing and social care.

3. Complexities in Discharge Planning

- Differences in assessment between clinical teams, such as social workers and medical staff identifying different levels of need.
- Patients, carers, and families often feel shut out of crucial discharge decisions.
- Concerns about premature discharges, inadequate care packages, and “bulk discharges” on Fridays.

4. Preventative & Community-Based Approaches

- We heard that there is strong support for prevention and admission avoidance, particularly through:
 - Community Mental Health Teams
 - Third Sector partnerships
 - Supported housing
- How do we shift toward balanced investment and a stronger focus on prevention when service demand remains high?

5. Shared Electronic Systems & Information Sharing

- Health & Social Care can only see part limited patient history. This means people have to repeatedly share information to multiple professionals. Things can get missed and people overlooked.
- Barriers due to incompatible IT systems.
- Shared systems would support better joint working, but communication is vital.
- Reliance on records means staff sometimes do not know who is responsible for different aspects of discharge.





6. Improving the Discharge Process

Key issues

- The planned discharge date isn't always communicated clearly between professionals, patients, carers or their families.
- Staff report on lack of clarity on who is involved in discharge and what their role is.
- Carers report they felt excluded from the process, despite being the people who best understand the individual's daily needs.
- Discharges are delayed when staff are not enabled to make timely decisions or bring in the appropriate support teams, meaning patients are not supported to go home quickly.
- Training opportunities not reaching frontline staff.

What's working

- The culture is changing, with greater focus on promoting patient activity as part of preventing PJ paralysis.
- A new regional discharge approach is currently being tested at Ysbyty Aneurin Bevan (YAB) for patients from Blaenau Gwent. This model involves a dedicated team reviewing each patient to ensure clearly defined roles and clarity across all aspects of the discharge plan.

7. Data & Outcomes

- There is a need for stronger data collection, including gathering examples of positive practice.
- Better data would enable teams to identify patterns linked to inappropriate discharge, helping to prevent repeat admissions.

8. Wider Considerations

- SAFER principles need embedding from day one of admission, including conversations with families and carers.
- Importance of shared training across health and social care to improve communication and support meaningful discharge planning.

9. Person-Centred vs System-Centred Approaches

- There was a strong consensus in the room that the system currently feels system-centred and not person-centred.
- People want:
 - Clear explanations of the discharge process
 - Named contacts
 - Joint funding arrangements, with shared budgets across Health and Social Care services, that support people's actual needs
 - Better coordination between the five local authorities

Barriers to Timely Discharge: Insights from People's Journeys

A Real Experience

A person receiving inpatient care was ready to leave hospital in late 2025, but ended up staying 231 days, including 165 days of avoidable delay, because Section 117 funding for their support in the community wasn't agreed.

A suitable place for them to move to had been found, but the move couldn't happen because funding wasn't resolved, even after multiple meetings and escalation.

The extended stay led to a decline in wellbeing, increased reliance on staff, and a bed being occupied for much longer than needed.

What This Shows

- Delays in agreeing funding can stop a discharge, even when someone is clinically ready to leave
- Slow decision-making between organisations can cause avoidable harm and put pressure on already busy services

What Experiences Highlight

- Not enough suitable supported accommodation, especially for people with more complex needs
- Disagreements between health and social care about who should fund what
- Needs or risks being too complex for available community options
- Previous placements breaking down, increasing the risk of homelessness
- Temporary or short-term solutions not being robust enough

Quicker funding decisions, clearer processes, and more appropriate supported accommodation mean: Safer discharges, fewer delays, and better outcomes for the people who need support.

What people want to see

Discharge planning from day one

Clear roles, responsibilities, and next steps

Focus on positive practice and outcomes, not just families

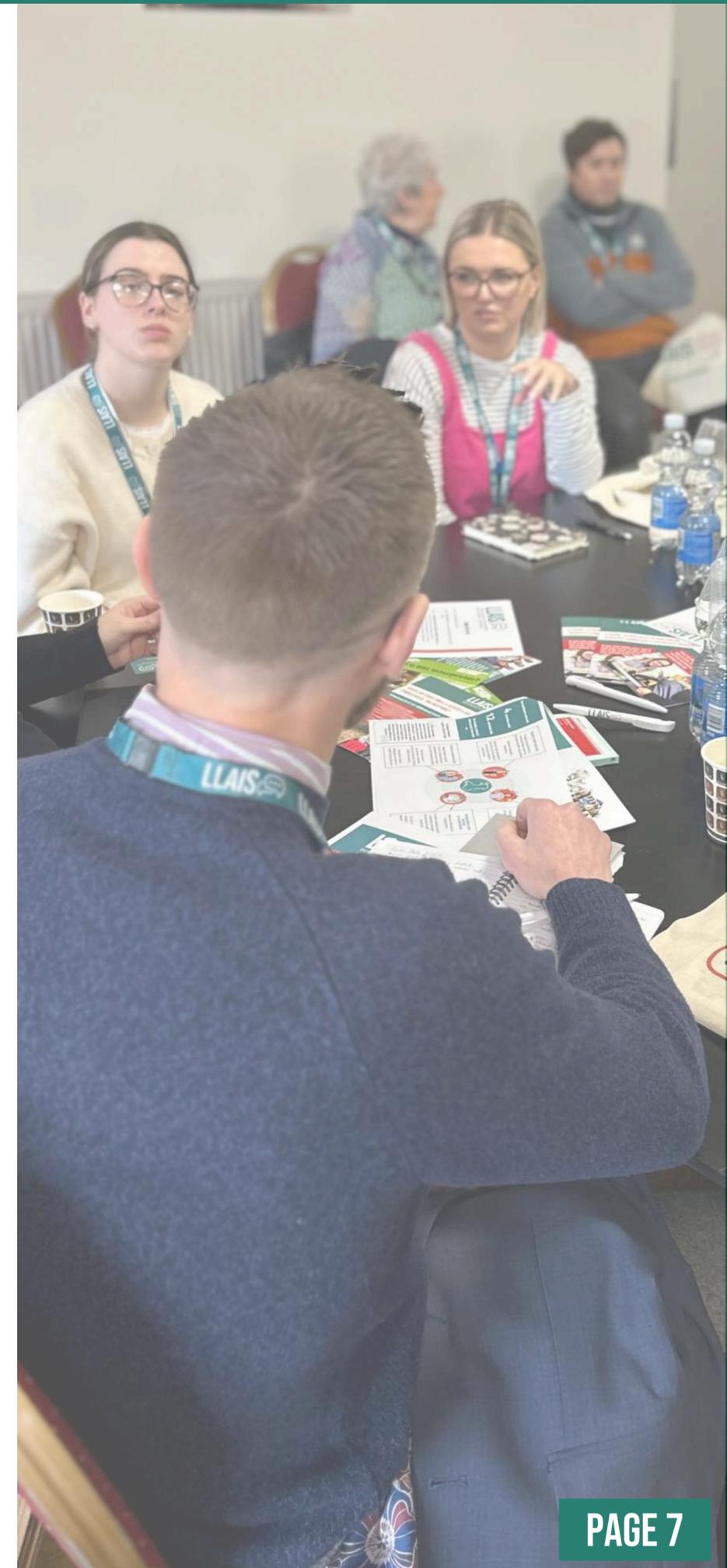
True person-centred planning supported by shared budgets

Shared systems and better information flow

Test-case collaborative project in mental health adopting a single pooled budget

Consistent involvement of mental health and learning disabilities

Stronger community prevention model



Your voice: Questions asked at the Summit

At our Summit, people asked Health and Social Care providers questions about hospital discharge:

1. How can mental health be better included in discharge planning?

Mental health is being considered as part of the overall discharge approach across all hospitals, led by the Executive Director of Nursing. This includes a broader understanding of mental health needs, including dementia, and how these impact discharge. It is also recognised that hospital settings are not always the most appropriate environment for assessing longer-term needs, which must be considered in discharge planning.

2. What more could be done from a preventative aspect?

Admission avoidance is high on priority focus for health and social care, whether there are physical or mental health needs, because we know if we can keep patients and clients well in their home, that's usually the safest and most desirable place to be, so it is one of our main focuses.

3. How can repeated discharges be reduced, discharge planning be strengthened from day one, and care better coordinated so that patients and families experience a more joined up approach across organisations?

Not all repeat discharges are failures; some are patient-led and appropriate when safely supported. Early, ongoing discharge planning and involving patients and families where appropriate are essential, while continued collaboration between organisations is needed to improve coordination and clarify roles.

4. What support is available when a patient has no family to advocate for them, and how can we ensure the discharge process remains person-centred rather than system-centred?

When a patient has no family involved, professionals such as housing teams, support workers and community connectors advocate on their behalf. Effective discharge relies on understanding and meeting the individual's needs and preferences. While some people may not initially engage, when they do, a range of support services can be used to ensure the process stays focused on the person, not the system.

5. What can be done to ensure timely, clear communication from day one for patients being discharged, and to make sure the discharge plan is appropriate, followed consistently, and supported throughout the process?

We recognise that discharge planning must start on day one. We are committed to setting out a clear plan early, sharing it with patients and families, and making sure everyone understands their role. We also know plans can change, so we will review them regularly and keep communication consistent throughout to ensure people feel supported and informed at every stage.

Next steps

Thank you to those who attended our summit and shared your time, experiences and ideas.

Your voices showed why co-production matters.

Working together with people, carers, health and social care to make things better. What you told us will help shape future work and support more joined-up services that work around people and families.

