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GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

Our ref: NP25-57

6th October 2025

Rob Simkins
Head of Policy and Public Affairs Carers Wales
Unit 5 Ynys Bridge Court
Cardiff
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Dear Rob Simkins

RE: Track the Act Information Request 2025

Thank you for the opportunity to respond to information in respect of 'Track the Act' 2025. In response to your questions please see below: -

Section 1: Hospital Admission and Discharge

a) How do you identify an unpaid carer who is admitted to hospital, and what support exists for the person(s) they care for throughout their admission to hospital?

The importance of identification, assessment and support of carers as expert partners in hospital discharge is well recognised. ABUHB prioritises early identification of unpaid carers and ensures both carers and the people they care for receive timely support. This includes practical assistance, emotional support, and signposting to statutory and voluntary services to maintain continuity of care during hospital admissions. Unpaid carers are identified through multiple, complementary routes:

- **Admission**. During hospital admission, staff routinely ask patients about any caring responsibilities. This includes questioning by nurses, doctors, and discharge coordinators. Ward staff are trained to recognise signs that a patient may have caring responsibilities even if not initially declared.
- **Awareness and Signposting**. There are posters displayed and information available across the Gwent hospital sites encouraging carers to make themselves known. Staff are trained to recognise signs that a patient may have caring responsibilities or are looked after by a carer. Staff are encouraged to ask the questions: "Are you looking after someone or does someone look after you?" during admission and care planning conversations.
- **Carers Needs Assessment**. In line with the Social Services and Well-being (Wales) Act 2014, carers are entitled to a Carer's Needs Assessment. This assessment can be requested, and carers are signposted to the local authority. The assessment helps identify the carer's needs and what support is available for carers to continue their caring role safely and effectively.
- **Support for the Person(s) Cared For**. When an unpaid carer is admitted to hospital, we ensure that the person(s) they care for continue to receive appropriate care and

support where needed through immediate welfare checks where hospital staff and social services work together to ensure the safety and wellbeing of the cared for person, especially if they are vulnerable. Social services can arrange emergency respite care or temporary support to maintain continuity of care.

- **Community and Voluntary Sector Support.** ABUHB collaborates with organisations such as GAVO, Carers Wales, Llais, and Carers Trust Wales to provide advice, guidance, and support.
- **Information and Signposting.** Carers and their families are provided with information about local authority contacts and voluntary organisations that can offer additional support. Each local authority in the ABUHB area has a dedicated contact number for carers to request assessments and support.

- **Carers Information Hubs**. ABUHB has Carers Information Hubs at five of our hospital sites (The Grange, Ystrad Mynach, Royal Gwent, Neville Hall and Ysbyty Aneurin Bevan) These operate 4 days a week between the hours of 10.00 – 14.00 (with provision for out of hours support), offering advice and support to carers and their families. The hub staff also regularly visit the wards to help identify and support carers

- **Diverse communities**. We support a project that identifies and supports the unique needs of carers from diverse communities

- **Hospital Information Boards** All hospital ward beds have hospital information boards where the carer /cared for can identify the unpaid carer role and provide relevant information about what matters to them.

- **Recognition through work programmes**. There are times when going to hospital does not result in a hospital admission and carers are identified through these processes e.g. Home First (a trusted assessor model to enable turn around at the front door where appropriate.) or Same Day Emergency Care; a model that integrates medical and surgical intervention together.

  In addition to this carers may be identified through system processes e.g. Hospital to a Healthier Home (quicker, safer discharges of care in partnership with Care and Repair), optimal hospital patient flow (supports flow through health and social care systems, to ensure people who possess a clinical need for admission to hospital are discharged home when clinically ready, with the right support and without delay), discharge and transfer lounges, discharge teams, discharge to Recover and Assess models (supports timely and safe discharges of patients), single point of access for emergency and urgent care,(aimed towards providing care closer to home and avoiding unnecessary hospital presentation or admission) and community based falls response services

b) How do you make carers in hospital settings aware of what information exists to support them with their caring role?

At Aneurin Bevan University Health Board, we recognise the vital role that carers play in supporting patients, both in hospital and at home. Ensuring carers are aware of the information and support available to them is a key part of our commitment to person centred care**.** This is achieved through:

- **Clear Signposting and Information and material**s. We provide dedicated carer information leaflets on wards, at carers hospital hubs and in public areas, outlining support and how to access local and national resources. Leaflets are also available online

via the ABUHB Carers webpage. Our Patient Information Leaflets portal includes resources on a wide range of topics, including support for carers.

- **Johns Campaign.** We operate John's campaign across our regional footprint allowing flexibility for carers visiting hospitals.

- **The Chaplaincy service** includes carer identification, information and support

- **Staff awareness and proactive communication.** Staff have been trained to identify carers and proactively offer information about support services, including Carer's Needs Assessments. We understand this is an ongoing commitment and we work with Carers Trust Wales to help develop a new training package in a format that will be accessible to all staff in the near future. We continue to use Carer awareness campaigns such as Carers Week, Carers Rights Day and Young Carers Action Day to promote unpaid carers.

- **Carers champions**. Some wards have designated Carers' Champions who can provide information and signpost carers to further support.
- **Direct Support:** Carers can request a carer's assessment, which helps identify their needs and the support available, in line with the Social Services and Well-being (Wales) Act 2014. Contact details for local authorities and voluntary organisations are provided in our materials and on our website. [Carers - A...alth Board]
- **Online Resources:** The ABUHB website hosts a comprehensive Carers section with links to local and national organisations, carer strategies, and self care advice.

- **Community Links and Third Sector Collaboration.** We work closely with local authorities and voluntary organisations such as Carers Wales and Carers Trust Wales to ensure carers can access advice, peer support, and respite services.

- **Feedback and Continuous Improvement.** We regularly seek feedback from carers to improve the information and support we provide, ensuring it remains relevant and accessible.

c) When a carer is discharged from hospital, what processes are in place to ensure that the carer is asked whether they are willing and able to provide care?

Where carers want to be identified and involved, we make every effort to ensure carers are consulted, informed, and empowered regarding their role prior to discharge. Through early engagement, structured conversations, consent based care planning, and signposting to assessments and support services, carers' willingness and ability to provide care are formally assessed, safeguarding both the patient and the carer.

Our core principle is that no carer should be expected to provide care and ABUHB has clear processes to ensure carers are asked about their willingness and ability to provide care at discharge. This includes early identification, informal and formal assessment, explicit consent, and ongoing support, all underpinned by policy and legislation. The processes to assess this start early in the patient's admission and continues through discharge planning.

- **Early and ongoing discharge planning.** Discharge planning begins at the point of hospital admission. The hospital team will discuss the patient's home circumstances and the support they already receive or may need on discharge. Carers and families are encouraged to share any concerns or barriers to providing care at home as early as possible in the admission process. [Planning a...ersity ...]

- **Assessment of carer willingness and ability.** We understand that carers should not be expected to provide care unless they are both willing and able and no family member should be asked to undertake care tasks they do not normally provide, do not wish to continue providing, or have not consented to. This is especially true for tasks requiring training or that are outside the carer's usual role. Staff conduct informal "What Matters to You" conversations with carers. This is an informal assessment designed to identify any support or services the carer may need and to ensure that care arrangements are safe and appropriate. It also helps us to understand their capacity, willingness, and support needs.

- **Carers needs assessment.** If a carer is identified, staff are expected to signpost them for support and offer a Carer's Needs Assessment, in line with Welsh Government legislation. The data on assessments are held with the Local Authority.

- **Consent and Involvement in Care Planning.** Care planning and the delegation of care tasks must be personalised, assessed on an individual basis, and mutually agreed with patients, families, and nursing staff. The Health Board's guidance is clear that no care should be delegated to a carer without their explicit agreement and appropriate training if needed. This is to ensure safety and dignity for both the patient and the carer.

- **Multi-disciplinary team (MDT) meetings**. Carers are included in multi-disciplinary team meetings and discharge planning discussions, where their views and capacity to provide care are considered before any discharge plan is finalised. [Planning y...pens next?]

- **Support and Signposting.** Carers are provided with information about available support services, respite care, and voluntary sector resources. Carers may also be referred to the on site hospital carers hubs. Posters and leaflets are displayed across hospital sites to remind carers of the support available and encourage them to seek help.

- **Post Discharge project**. We support unpaid carers who may need low level support to help with the discharge transition of their cared for returning to their place of residence. This includes assisting carers with household tasks, picking up prescriptions and supporting benefit claims.

d) When a person who has an unpaid carer is ready to be discharged from hospital, what processes are there to ensure there is meaningful consultation with their carer(s) in discharge planning. This can include discussing timeframes, additional needs the person may now have, and support the person and/or carer may require on discharge?

Aneurin Bevan UHB has clear processes to ensure unpaid carers are identified, consulted, and supported throughout the discharge planning process. This includes early involvement, clear communication, respect for carer preferences, and access to assessments and support services. We are committed to involving unpaid carers in all stages of discharge planning, ensuring their views, capacity, and support needs are recognised and addressed from point of admission.

- **The Social Services and Well-Being (Wales) Act 2014.** Unpaid carers are legally entitled to an assessment of their own needs; separate from the needs of the person they care for. This assessment can be requested at any time and is free of charge. [Carers - A...alth Board]. The Health Board commits to identifying carers early, treating them as 'Partners in Care', and involving them (with patient consent) in all stages of care, treatment, and decision making, including discharge planning. Carers are provided with information about their rights, support services, and are encouraged to express how involved they wish to be.

- **Discharge Planning Process**
  - **Early Identification.** On admission, staff are expected to ask about anyone who helps the patient at home, not just those who identify as 'carers. This ensures unpaid carers are identified from the outset. [Involving...er of care]
  - **Consultation and Communication.** Carers are included in "What Matters to you" conversations to ensure their insights, concerns and capacity is heard. They are informed about any changes in the patient's care needs and are given a copy of the discharge plan. Written information is provided about technical aspects of care (e.g., medication, mobility, nutrition) and what to do if problems arise. Carers are encouraged to ask questions and express concerns at any stage.
  - **Consent and Confidentiality.** Adult patients with capacity decide who information can be shared with. Staff must check and record permissions. Even if full consent isn't given, carers have the right to enough information to make an informed decision about their caring role.
  - **Carer Assessment and Support**. Carers are informed of their right to a Carer's Needs Assessment. Signposting is provided to local authority services and voluntary organisations [Carers - A...alth Board]. Carers can also be signposted to the carers hospital hubs for information and advice. We currently operate a post discharge service offering low level support to carers upon discharge which includes help with household chores or shopping to help the carer cope with the transition from hospital to home.
  - **Staff Responsibilities.** Staff involve carers in discharge planning meetings with dates agreed in advance and keep them updated on patient progress toward discharge. This may include carer perspectives in multi-disciplinary team discussions. Staff also signpost to community support services and how to access them. Carer Awareness training is offered to staff to improve understanding and support for carers.
  - **Carer Responsibilities.** We encourage carers to make themselves known to staff, ask for support if needed and communicate how involved they wish to be.
  - **D.A.V.I.D.** We have introduced the D.A.V.I.D (Details And Vital Information Document) for carers. This provides clear, timely, and accurate information that supports appropriate treatment, care decisions, and discharge planning and helps to avoid carers repeating themselves in explaining their caring role and what matters to them.

The following table summarises the Discharge steps as appropriate to carers.

Steps in Discharge	Carer Involvement/Assessment
Admission	Carer identified, home circumstances discussed
Early Planning	"What matters to you" conversation with patient and carer
Assessment	Carer's willingness and ability assessed; Carer's Needs Assessment offered
Care Planning	Carer's consent required for any delegated care; involvement in MDT meetings

Steps in Discharge	Carer Involvement/Assessment
Discharge	Carer signposted to support; information provided; ongoing review if needed

e) If someone is being discharged with significant and/or permanent negative changes to their health, what processes are there to discuss this with person(s) perceived to be in a position to support and ask if they are willing and able to provide care for the person moving forward?

When a patient is being discharged with significant or permanent changes to their health, there are structured processes in place to involve and support unpaid carers, family members, or others perceived to be in a position to provide care. These processes are guided by the Welsh Government's Hospital Discharge Guidance (January 2025). [Hospital d...GOV.WALES]

We ensure carers and support persons are actively engaged in planning for patients with significant health changes. Through early conversations, needs assessments, legal guidance, care coordination, and access to advocacy and support services, carers are empowered to make informed decisions about their willingness and ability to provide care.

- **Early identification and engagement.** From the point of admission, patients are assessed and provisionally placed on one of four Discharge to Recover then Assess (D2RA) Pathways. This helps identify the level of support they will need post discharge. Health professionals are expected to begin conversations early with the patient and their family or carers about home circumstances and potential support needs.

- **Legal Right to Choose.** Under the Social Services and Well-being (Wales) Act 2014, carers have the legal right to decide whether they are willing and able to take on a caring role.

- **Carer's Needs Assessment** Carers are entitled to a Carer's Needs Assessment, which can be conducted at any time including while the patient is still in hospital or after discharge. This assessment considers the carer's capacity, emotional and physical health, and other life commitments ensuring any care provided is safe and sustainable.

- **Trusted Assessor and Care Coordinator roles.** These roles are designed to facilitate communication and coordination between the patient, carers, and health/social care teams. They help determine what short-term care is needed and who will provide it, ensuring carers are not left unsupported.

- **Information and consent.** Carers are kept informed and consulted throughout the discharge planning process. The patient's consent is required for sharing information, but the health board also recognises it has a duty to ensure carers are involved appropriately.

- **Support and advocacy.** ABUHB and partner organisations provide access to advocacy services and information resources to help carers navigate the discharge process and understand their rights.

f) If unpaid carers are identified and involved within discharge planning, how is this communicated to community healthcare and social care providers?

ABUHB ensures that carer involvement is formally recorded, communicated, and coordinated with community healthcare and social care providers. Through early identification, multi-disciplinary team engagement, clear referral pathways, structured documentation, and ongoing review, carers' roles are recognised and supported, ensuring continuity of care for the patient and safeguarding the wellbeing of both carers and those they care for.

- **Early identification and consent.** Upon admission, ward nurses assess the patient's home circumstances and support needs. If social care support is required, the patient (or their carer) is asked for consent to refer to the Adult Social Services Department in their local area.

- **Multi-Disciplinary Team (MDT) Involvement.** A team comprising doctors, nurses, discharge coordinators, occupational therapists, physiotherapists, dieticians, pharmacists, and social workers collaboratively assesses the patient's needs. The MDT discusses the discharge plan with the patient and their unpaid carer, ensuring their role and capacity are considered. Carer input is actively sought and considered in all discharge planning discussions.

- **Referral and Communication Pathways.** Once carers are identified and involved, in the discharge plan, their role is communicated to relevant community services, including:
    - District Nursing Services
    - Reablement Teams
    - Social Workers managing care packages
    - Community Hospitals or Step-Down Beds
    - Residential or Nursing Care Providers

Where needed social workers coordinate care packages and liaise with care agencies, ensuring carers are informed and supported. Reablement teams may work directly with carers to support short term recovery goals at home

- **Documentation and Handover.** A care plan, including details of the patient's needs and the carer's role, is created and shared with community providers. This plan is used by care agencies and community teams to ensure continuity of care.

- **Ongoing Support and Adjustment.** Post discharge, care arrangements (including carer involvement) can be adjusted based on feedback and reassessment by community teams, patients and carers.

g) If any of these processes are not uniform across the health board, please give us the differences and explanations for why there may be differences in approach

While Aneurin Bevan University Health Board (ABUHB) has made significant progress in supporting unpaid carers, there are differences in how processes are implemented across sites. These variations are influenced by local practices, resources, and system constraints and we recognise the need to continue to work on embedding standardised processes and improving communication, training, and IT systems to achieve consistent, high-quality support for all carers.

- **Variation in communication and tools.** Discharge tools such as flowcharts and checklists exist but are not always co developed or fully aligned with community and social care providers. Some wards may use different documentation or have varying expectations for what information is shared with external teams.

- **Local arrangements and reliance on individual practice.** Predicted waiting times for services (e.g., care packages, reablement) are often based on local arrangements rather than a uniform, health board wide systems. This can lead to differences in how and when unpaid carers are informed about what to expect after discharge.

- **Awareness of hospital policies**, such as transport booking and referral pathways, varies by site, with some staff relying on informal or locally developed processes rather than standardised, board wide / All Wales protocols leading to differences in how and when carers are informed about post discharge support.

- **Data recording and IT systems.** Carer information is not routinely or uniformly recorded across health board systems. Fragmented IT systems across primary, secondary, and social care hinder standardised communication, making it harder to track carer involvement consistently and ensure that carer involvement is always visible to all relevant providers. This is a national challenge, but it is particularly acute in areas where multiple systems are in use, leading to gaps in communication and support for unpaid carers.

- **Partnership and joint training.** Joint training and induction with local authority partners is not yet fully embedded. Some sites have more integrated working and better communication with social care, while others are still developing these relationships. Refresher training for staff on discharge planning and carer involvement is inconsistent, which can lead to differences in practice. Optimal Hospital Flow Framework is aiming to address this. However positive progress will take time to appropriately embed across the organisation.

- **Funding and Project Based Initiatives.** Certain improvements or pilot projects (e.g., targeted carer support, new discharge pathways) are dependent on short term funding. This means that certain services or communication pathways may only be available in specific localities or for limited periods. There are a number of reasons for this.
    - **Legacy systems and local autonomy.** Different hospitals and teams have developed their own ways of working, often in response to local needs or resource constraints.
    - **IT and data challenges.** Lack of integrated IT systems makes it challenging to standardise processes and share information seamlessly.
    - **Funding uncertainty.** Annual or project based funding for carer support leads to variability in what is available and how it is delivered.
    - **Partnership working still developing.** While there is a commitment to integrated care, true joint working and shared training are still being embedded.

Section 2: Provision for carers

a) What specific measures are put in place within your primary, secondary and tertiary settings to support unpaid carers directly? This can be for unpaid carers supporting people in receipt of treatment or for carers who are receiving treatment themselves

We support unpaid carers across all care settings through information provision, assessment, training, direct support, collaborative partnerships, and specialist services. This holistic approach recognises carers' vital role and ensures they have access to practical, emotional, and financial support both during hospital care and in the community. In addition to this a

robust structure for monitoring progress exists through strategic partnerships, leadership groups and regional partnership Boards., with reports submitted to Welsh Government on supporting carers in line with national priorities

- **General support for unpaid carers**

    - **Definition of Carers**: ABUHB recognises carers as anyone (adult or child) who provides or intends to provide unpaid care to a family member, partner, or friend unable to cope without support due to illness, disability, mental health issues, or frailty.
    - **Carer's Needs Assessment**: Carers are entitled to a Carer's Needs Assessment under the Social Services and Well-being (Wales) Act 2014, identifying support needs rather than assessing ability to care. Local Authorities hold data on assessments
    - **Referral Pathways**: Carers can request assessments through their local authority (Blaenau Gwent, Caerphilly, Monmouthshire, Newport, Torfaen).
    - **Data for carers** hospital discharge projects is collected using the national regional integration fund templates and local monitoring.

- **Primary Care & Community Services**
    - **Gwent Frailty Service**. A multi-disciplinary team that supports patients and carers in the community, helping to avoid unnecessary hospital admissions and supporting early discharge.
    - **Community nursing & rehabilitation**. These services often work closely with carers, offering training, advice, and support to help them manage care at home.
    - **Melo Cymru** offers mental health and wellbeing resources for carers in the community.

- **Secondary Care (Hospitals)**
    - **Carers Information Hubs**. These are lLocated at five hospital sites, these hubs provide information, signposting, and guidance to carers navigating the healthcare system.
    - **Post discharge Support**. This is a project funded to support carers with low level support when someone is discharged to enable them to continue caring.
    - **Discharge and diversity**. A project supporting hospital discharge for those of diverse communities.
    - **Patient Liaison Service**: A 7-day week service that supports patients and carers in hospital
    - **Hospital Discharge Support**: Carers are involved in discharge planning, and ABUHB ensures they are offered support and assessments during this process.
    - **Awareness Campaigns**: Posters, materials and national carer awareness days across hospital sites raise awareness of carers' rights and available support.

- **Tertiary and Specialist Services**
    - **Macmillan Welfare Benefits Service**. This supports carers of cancer patients with financial advice, form filling, and grant applications at Royal Gwent and Nevill Hall Hospitals.

- **Mental Health Services**. In partnership with Citizens Advice, ABUHB offers tailored support for carers of individuals with mental health needs, including help with benefits, housing, and emotional wellbeing.

- **Third Sector and Collaborative Support.** ABUHB works closely with many third sector organisations and carers groups. Some examples are:
  - Carers Wales and Carers Trust Wales for advocacy, advice, and peer support.
  - GAVO (Gwent Association of Voluntary Organisations) to strengthen community based carer support.
  - Disability Advice Project for welfare rights and practical support
  - Adferiad for supporting carers with mental health
  - Age Connects Torfaen for supporting carers of those living with dementia
  - Primary and secondary schools, colleges and university across Gwent to support young/young adult carers

b) How have you worked with local authorities in your area to provide support for unpaid carers?

Aneurin Bevan University Health Board (ABUHB) works closely with the five Gwent local authorities (Blaenau Gwent, Caerphilly, Monmouthshire, Newport, Torfaen) through formal partnerships, shared funding, and joint service delivery to support unpaid carers. This includes practical help (grants, respite, assessments), emotional support, awareness raising, and targeted programmes for young carers. The approach is holistic, aiming to recognise carers' needs at every stage, especially during hospital discharge and in the community.

This collaboration is both strategic and operational, covering hospital discharge, community support, and targeted initiatives.

- **Joint Working and Strategic Partnerships**
  - **Gwent Regional Partnership Board (RPB)**: ABUHB collaborates with the five Gwent local authorities (Blaenau Gwent, Caerphilly, Monmouthshire, Newport, Torfaen), third sector partners, and carer organisations through the Gwent RPB. This board oversees joint projects, funding, and the delivery of carer support services across the region.
  - **Implementation Structure.** A robust implementation structure is in place whereby the carers operational group is represented by all the local authorities and reports into the Gwent Strategic Partnership, where further Local Authority senior strategic representation exists. Progress is monitored through formal reporting mechanisms, including annual updates to the Welsh Government on achievements and challenges in supporting carers.
- **Key Support Initiatives**
  - **Carers Needs Assessment.** Unpaid carers are entitled to a Carers Needs Assessment under the Social Services and Well-Being (Wales) Act 2014. This is promoted at the point of hospital discharge, with staff encouraged to signpost carers for assessment and support to the local authorities. [Carers - A...alth Board]
  - **Gwent Home First Model.** This service works with local authorities and supports hospital discharge 7 days a week, helping carers and patients move safely from hospital to home, and providing alternatives to admission where possible.

- **Gwent Carers Hub.** Located in Pontypool, this regional Hub offers a safe space for unpaid carers to discuss their needs, access advice, and receive one to one support. Outreach workers also visit local authority areas for those unable to travel. [Gwent Care...- Adferiad]. Support provided includes emotional, practical, and financial wellbeing support, signposting, help with grant applications, carers groups, and events
- **Carers grant schemes.** ABUHB partnership supports a small grant scheme for carers and Local authorities work in partnership to help provide direct grants to carers needing support
- **Young Carers in Schools Accreditation Programme.** The Gwent carers strategic partnership supports a dedicated programme that identifies and supports young carers in schools, addressing educational, emotional, and social needs.
- **Respite and wellbeing.** We work in partnership to support the Bridging the Gap scheme which provides short breaks and respite care, allowing unpaid carers to take a break from their caring role **[Bridging T...t - NEWCIS]**
- **Awareness, training, and information.** Awareness Campaigns**.** Posters and information are displayed across hospital sites to raise awareness of unpaid carers and encourage them to seek support. Staff are trained to recognise and support carers, including signposting to local authority services and voluntary sector partners.

- **Multi-disciplinary and community-based support**

- **Community resource teams.** Joint teams of health and social care professionals provide support to help people remain independent at home, reducing unnecessary hospital admissions and supporting early discharge. [Community...tter Gwent]

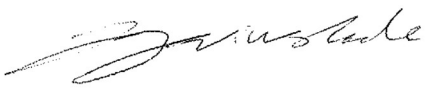
Section 3

If you could ask questions to Health Boards relating to unpaid carers in future iterations of Track the Act, what would they be?

Traditionally Track the Act requests have been aligned to the Welsh Government national priorities and expectations. Given the reliance placed on Welsh Government funding to deliver the carers priorities and the changing climate at the Senedd in the forthcoming year, it is challenging to predict the priority themes in the context of future iterations without knowing what policies will be supported.

I trust this answers your questions. Please don't hesitate to get in touch if you need any further information.

Yours sincerely



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