Agenda Item: 8

Meeting of:	**Governance and Audit Committee**
Date of Meeting:	**Monday, 21 July 2025**
Relevant Scrutiny Committee:	Resources Scrutiny Committee
Report Title:	Urgent and Emergency Care: Flow out of Hospital - Cardiff and Vale Region
Purpose of Report:	To advise Members of the findings of the Auditor General for Wales' review of Urgent and Emergency Care: Flow out of Hospital - Cardiff & Vale Region
Report Owner:	Tom Bowring, Director of Corporate Resources
Responsible Officer:	Tom Bowring, Director of Corporate Resources
Elected Member and Officer Consultation:	No specific ward member consultation has been undertaken. Regulatory reports apply to the whole authority and inform Scrutiny Committees' annual work programme, the Cabinet annual work programme and the Council's improvement programme. Progress in relation to areas for improvement arising from the Annual Regulatory Plan (including local and national reviews) is regularly reported via the Council's Strategic Insight Board Insight Tracker to the Strategic Leadership Team, Governance & Audit Committee and Cabinet for final oversight.
Policy Framework:	This is a matter for Executive decision by Cabinet.

Executive Summary:

- This review of urgent care undertaken in 2023/2024 forms part of a broader programme of work being undertaken by the Auditor General for Wales in respect of urgent and emergency care services in Wales. **Appendix A** sets out the findings from the review of the arrangements to support effective flow out of hospital in the Cardiff and Vale Region. The region encompasses the following statutory bodies:
  - Cardiff & Vale University Health Board;
  - Cardiff County Council; and
  - Vale of Glamorgan Council.
- The review was undertaken to help fulfil the Auditor General's duties, specifically to satisfy the Auditor General that NHS bodies and local authorities have proper arrangements in place to secure the efficient, effective, and economical use of resources, as required by Sections 17 and 61 of the Public Audit Wales Act 2004.

- Audit Wales concluded that, ' Overall, we found that whilst the volume of patients experiencing delayed discharge remains a concern, there have been notable improvements in ambulance handover and emergency department waiting time performance in the region. However, patient flow within hospitals is impacting negatively on other pathways of care, and regional partners will need to maintain their joint commitment to secure the improvements which are necessary.'
- Seven recommendations have been made in relation to the review which are detailed in **Appendix A**.
- In response to the recommendations, a combined management response has been developed and is being progressed by the statutory bodies. This is contained in **Appendix 5** of the attached report.
- This shows that at the time of reporting, good progress has been made in addressing all recommendations, with those directly involving local authorities (R1, R2, R5 and R7) already in place. These relate to the capturing of risks associated with social care capacity by local authorities to help inform discussions round discharge (R1), updating of the Health Board's discharge and associated policies (R2), establishment of arrangements to embed and deliver a seven-day working week approach to hospital discharge to minimise unnecessary stays in hospital (R5), and use of relevant performance data by the Regional Partnership Board to inform discussions and key decisions (R7).
- In line with the Council's performance monitoring arrangements, progress against regulatory improvement areas as they relate to the Council will be monitored via the Strategic Insight Board Insight Tracker. Governance & Audit Committee will continue to be informed of progress against our regulatory improvement areas through a six monthly and annual review of regulatory progress, with Cabinet having final oversight. Progress will also be monitored by Audit Wales as part of the Council's annual audit work programme.
- Governance & Audit Committee members are being asked to consider the contents of the appended report (**Appendix A**) including the combined management response and progress to date from the statutory bodies to the audit recommendations contained in **Appendix 5** of the report with any recommendations /comments being referred onto Cabinet for their consideration and endorsement.
- Additionally, the Senedd completed an Inquiry into the role of Local Authorities in supporting hospital discharges. The Association of Directors of Social Services Cymru provided significant evidence in relation to this. A copy of this can be found at **Appendix B** for members consideration.

Recommendations

1. That members consider the findings from Audit Wales' review of Urgent and Emergency Care: Flow out of Hospital - Cardiff and Vale Region **(Appendix A)** and the combined management response and progress to date from the statutory bodies to the review findings and Audit Wales' recommendations **(Appendix 5 contained within the report).** Additionally, Governance & Audit Committee members are also asked to consider the evidence presented to the Senedd Inquiry (**Appendix B**) which provides significant detail regarding the position of Social Services directors regarding delays across Wales.
2. That, subject to recommendation one, the report **(Appendix A),** Senedd Inquiry **(Appendix B)** and combined management response and progress to date as detailed in **Appendix 5** of the report be referred to Cabinet for their oversight and endorsement.

Reasons for Recommendations

1. To provide for scrutiny of the findings of Audit Wales' review of Urgent and Emergency Care: Flow out of Hospital - Cardiff and Vale Region.
2. To ensure the Council, in partnership with the relevant statutory bodies included in the review, responds appropriately and implements areas of improvement as identified by Audit Wales.

1. Background

1.1 The review was undertaken in 2023/2024 to help fulfil the Auditor General's duties, specifically to satisfy the Auditor General that NHS bodies and local authorities have proper arrangements in place to secure the efficient, effective, and economical use of resources, as required by Sections 17 and 61 of the Public Audit Wales Act 2004.

1.2 This review of urgent care forms part of a broader programme of work being undertaken by the Auditor General for Wales in respect of urgent and emergency care services in Wales. Work is also being undertaken to examine the arrangements in place to help manage urgent and emergency care demand, and to direct patients to the care setting that is most appropriate to their needs. The findings from that work will be reported separately.

1.3 Since the time of the report Welsh Government have commenced a number of new initiatives including a "Care Action Committee" chaired by the Cabinet Secretary, the 6 goals programme and last winter saw the 50 day challenge set by the Cabinet Secretary. Throughout these sessions Cardiff & Vale region were recognised has having some of the best performance in Wales.

2. Key Issues for Consideration

2.1 **Appendix A** sets out the findings from the review of the arrangements to support effective flow out of hospital in the Cardiff and Vale Region which encompasses Cardiff & Vale University Health Board; Cardiff County Council and the Vale of Glamorgan Council.

2.2 Audit Wales concluded that, ' Overall, we found that whilst the volume of patients experiencing delayed discharge remains a concern, there have been notable improvements in ambulance handover and emergency department waiting time performance in the region. However, patient flow within hospitals is impacting negatively on other pathways of care, and regional partners will need to maintain their joint commitment to secure the improvements which are necessary.'

2.3 Seven recommendations have been made in relation to the review which are detailed in **Appendix A**.

2.4 In response to the recommendations, a combined management response has been developed which is being progressed by the statutory bodies. This is contained in **Appendix 5** of the attached report.

2.5 This shows that at the time of reporting, good progress has been made in addressing all recommendations, with those directly involving local authorities (R1, R2, R5 and R7) already in place. These relate to the capturing of risks associated with social care capacity by local authorities to help inform discussions round discharge (R1), updating of the Health Board's discharge and associated policies (R2), establishment of arrangements to embed and deliver a seven-day working week approach to hospital discharge to minimise unnecessary stays in hospital (R5), and use of relevant performance data by the Regional Partnership Board to inform discussions and key decisions (R7).

2.6 In line with the Council's performance monitoring arrangements, progress against regulatory improvement areas as they relate to the Council will be monitored via the Strategic Insight Board Insight Tracker. Governance & Audit Committee will continue to be informed of progress against our regulatory improvement areas through a six monthly and annual review of regulatory progress, with Cabinet having final oversight. Progress will also be monitored by Audit Wales as part of the Council's annual audit work programme.

2.7 Governance & Audit Committee members are being asked to consider the contents of the appended report (**Appendix A**) including the combined management response and progress to date from the statutory bodies to the audit recommendations contained in **Appendix 5** of the report with any recommendations /comments being referred onto Cabinet for their consideration and endorsement.

2.8 Governance & Audit Committee members are also asked to consider the evidence presented to the Senedd Inquiry which provides significant detail regarding the position of Social Services directors regarding delays across Wales.

3. How do proposals evidence the Five Ways of Working and contribute to our Well-being Objectives?

Performance Management is an intrinsic part of corporate governance and integrated business planning which underpins the delivery of Vale 2030, the Council's Corporate Plan. Vale 2030 details five new Well-being Objectives which provide a framework for the next five years and how the Council will contribute to the national well-being goals. The five ways of working have been embedded in the development of the new Plan and are reflected in the work that will be undertaken to deliver Vale 2030.

3.1 External Regulation is an important vehicle for driving continuous improvement across our services. Progressing the improvement areas identified by our regulators not only enables us to demonstrate our commitment to continuous service improvement but also contributes to further strengthening our impact on the national well-being goals through the achievement of our well-being objectives.

3.2 The areas of improvement identified by our external regulators and the associated action plan produced by officers has been developed with the five ways of working in mind. The focus of these is on developing innovative ways of working that better integrate services, whilst enabling us to work more collaboratively with our partners and citizens to involve them in improving service delivery. These improvement actions also focus on preventative actions that will enable us to sustain and future proof our services into the longer term

4. Climate Change and Nature Implications

4.1 The climate change and nature implications in respect of our regulatory recommendations will be considered as part of the development of our response (action plan) where required and will identify mitigating actions required to minimise any adverse consequences.

5. Resources and Legal Considerations

Financial

5.1 There are no budgetary implications directly arising from this report, although failure to progress the improvement areas outlined in the report could have a negative impact on any future external regulatory assessments of the Council which could in turn put funding opportunities at risk.

5.2 Working at pace to facilitate early discharge from hospital adds to the budget pressures for Local Government – See Appendix 2

Employment

5.3 There are no direct workforce related implications associated with this report.

Legal (Including Equalities)

5.4 The statutory duties of the Auditor General are contained within the Local Government & Elections (Wales) Act 2021, the Well-being of Future Generations (Wales) Act 2015, the Public Audit (Wales) Act 2004, the Local Government Act 1999 and the Code of Audit Practice.

5.5 There are no implications directly arising from this report, although failure to respond to our regulatory recommendations could have a negative impact on any future external regulatory assessments and could result in a special inspection by the Auditor General for Wales if deemed that the Council is not meeting the performance requirements.

6. Background Papers

None

Archwilio Cymru
Audit Wales

Urgent and Emergency Care: Flow out of Hospital – Cardiff and Vale Region

Date issued: September 2024

Document reference: 4460A2024

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We welcome correspondence and telephone calls in Welsh and English. Corresponding in Welsh will not lead to delay. Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg. Ni fydd gohebu yn Gymraeg yn arwain at oedi.

Contents

Summary report

About this report

1 Once a patient is considered medically or clinically well enough to leave hospital (referred to as clinically optimised or medically fit) the timely discharge of that patient to the right setting for their ongoing needs is vital. Timely, effective, and efficient moving of patients out of an acute hospital setting holds important benefits for patient care and experience as well as for the use of NHS resources.

2 When the discharge process takes longer than it should there can be significant implications for the patient in terms of their recovery, rehabilitation, and independence. Delayed discharges will also have implications for other patients coming into the unscheduled care system[1] who need a hospital bed. Poor patient 'flow' creates bottlenecks in the system that contribute to well documented problems such as over-crowded emergency departments and an inability to secure timely handover of patients from ambulance crews.

3 The Auditor General had originally included work in his 2021 local audit plans to examine whole system issues affecting urgent and emergency care services, including the discharge of patients from hospital. The COVID-19 pandemic resulted in this work being postponed and brought back on stream in 2023. Our work has sought to examine whether health boards and local authorities have effective arrangements in place to ensure the timely discharge of patients out of hospital. The approach we adopted to deliver our work is detailed in **Appendix 1.**

4 This work is part of a broader programme of work the Auditor General is currently undertaking in respect of urgent and emergency care services in Wales. We are also examining the arrangements in place to help manage urgent and emergency care demand, and to direct patients to the care setting that is most appropriate to their needs. The findings from that work will be reported separately in 2024.

5 The Auditor General's work on urgent and emergency care is designed to help discharge his statutory duties. Specifically, this work is designed to satisfy the Auditor General that NHS bodies and local authorities have proper arrangements in place to secure the efficient, effective, and economical use of resources, as required by Sections 17 and 61 of the Public Audit Wales Act 2004. This report sets out the findings from the Auditor General's review of the arrangements to support effective flow out of hospital in the Cardiff and Vale Region (the region). The region encompasses:

- Cardiff and Vale University Health Board (the Health Board)
- City of Cardiff Council; and

[1] Urgent and emergency care describes any unplanned, urgent, and emergency care provided by health and social care services. The urgent and emergency care system is complex with numerous organisations involved in providing services and it deals with acutely unwell, vulnerable, and distressed people in need of urgent assistance.

- Vale of Glamorgan Council.

6 In undertaking this work, we have also considered progress made by the Health Board against previous recommendations made in our 2017 report on discharge planning. Our findings from this work are set out in a separate report to the Health Board.

Key messages

7 Overall, we found that **whilst the volume of patients experiencing delayed discharge remains a concern, there have been notable improvements in ambulance handover and emergency department waiting time performance in the region. However, patient flow within hospitals is impacting negatively on other pathways of care, and regional partners will need to maintain their joint commitment to secure the improvements which are necessary.**

8 In line with trends across Wales, the numbers of patients whose discharge from hospital in the Cardiff and Vale region have grown significantly in recent years. Between April 2023 and February 2024, each month there were on average 194 clinically optimised patients whose discharge was delayed, with completion of social care assessments and social worker allocation the main causes for delay. While this represents the best position in Wales, except for Powys, it remains a cause for concern. For the period April 2023 to February 2024, the total number of bed days that had been lost to delayed discharges was 50,668 with a full-year cost equivalent of £27.637 million for the Health Board.

9 The Health Board has, in recent months, had significant success in preventing delayed discharges from impacting on patient flow within its urgent and emergency care system, with performance across metrics for waiting times in emergency departments and ambulance handovers consistently either the best in Wales or well above the all-Wales average performance. In January 2024, lost ambulance hours accounted for 834 hours, compared to 2,722 in August 2022. However, data indicates that the commitment to improving waits at either end of the hospital within urgent and emergency services may be impacting on flow within the hospital. Data indicates that access to beds on specialist wards, such as stroke, is inconsistent and that greater numbers of scheduled (planned) care appointments are cancelled due to the lack of available beds within the hospital.

10 Several factors are contributing to delayed discharges. The region has an ageing population with a correlating increase in people who live with complex, long-term conditions including mental health problems. There are also workforce challenges within the social care sector, which is resulting in delays in the allocation of social workers and in completing social care assessments. Our work also identified weaknesses in the practice and documentation of discharge planning and a need to include the Discharge to Recover and Assess (D2RA) model within its policies. However, the region is successfully managing to meet demand for care support, with it able to provide care in line with its commitment to providing domiciliary care

over care home provision. This is something many other regions in Wales are finding challenging.

11 Improving patient flow is a key feature of plans across the partners which align to the Welsh Government's six goals for urgent and emergency care[2]. Partners are working together effectively, both strategically and operationally, to improve patient flow. Financial resources are being applied to improve discharge planning with evidence of evaluation of the impact of projects and initiatives. There is regular monitoring of performance within individual organisations and with partners, but we found scope for further opportunities to examine whole system solutions, embed learning and to focus on the impact of activity within performance and progress reports.

Recommendations

12 Recommendations arising from this audit are detailed in **Exhibit 1**. The combined management response by the statutory bodies included in this review to these recommendations will be summarised in **Appendix 4** once considered by the relevant committees.

Exhibit 1: recommendations

Recommendations
Addressing key gaps in social care capacity
R1 To help inform discussions around discharge, the local authorities should capture the risks associated with social care capacity on the provision of services at a local and regional level, including the impact on patient flow out of hospital.

[2] Further information on the Welsh Government six goals for urgent and emergency care can be found via https://www.gov.wales/written-statement-six-goals-urgent-and-emergency-care-programme-update

Recommendations

Improving compliance with policies and guidance

R2 The Health Board, working with local authorities, should update its discharge policy and associated policies, including the choice of accommodation policy, to provide clarity to all staff on how the discharge planning process should work across the region. This should be based on the national guidance issued in December 2023, set out clearly defined roles and responsibilities, and expectations, and reflect the Discharge to Recover then Assess model. The process for updating the policy should include patients and carers.

R3 The Health Board should embed a regular cycle of audit to assess the effectiveness and consistency of the application of the discharge policy and associated training programmes.

Improving the quality of information

R4 The Health Board should improve record keeping by:

- 4.1 ensuring all staff involved in discharge planning fully understand the importance of documenting comprehensive information in patient case-notes to support effective discharge planning; and
- 4.2 establishing a programme of case-note audits focused on the quality of record keeping.

Maximising weekend discharges

R5 The Health Board, in partnership with its local authorities, should ensure it has the necessary arrangements in place to embed and deliver a seven-day working week approach to hospital discharge to minimise unnecessary stays in hospital.

Increase clarity of intended outcomes for pathways of care action plan

R6 The region should ensure its action plan for pathways of care is clearer on the intended outcomes from the actions it has identified. It should also undertake regular review to assess whether outcomes are being achieved.

Recommendations

Maximising the use of the Regional Integration Fund

R7 To help inform decision-making and discussions, the Health Board and local authorities should ensure that the Regional Partnership Board has routine access to key performance indicators relevant to effective and timely flow out of hospital, including urgent and emergency care performance within the Health Board and waiting lists for social services and care packages

Detailed report

What is the scale of the challenge?

13 This section sets out the scale of the challenge that the region is facing in respect of delayed discharges and the subsequent impact on patient flow and the patient experience.

14 We found that **the region generally performs better than the all-Wales position for measures related to unscheduled care and discharge planning, though this focus may be impacting its ability to move patients to the most appropriate setting within the hospital.**

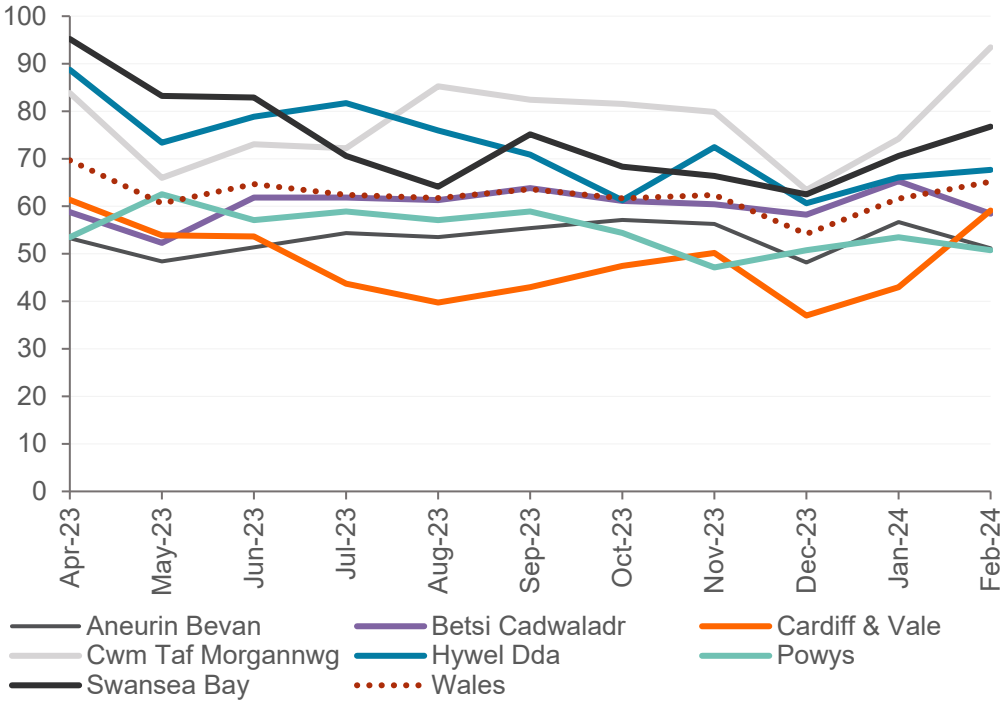
Delayed discharges

15 We found that **the region has comparatively lower rates of delayed discharges, with an improving trend in 2023-24, though those experiencing delays wait longer than the all-Wales average.**

16 Delays discharging patients from hospital has been a longstanding issue for bodies in Wales and other parts of the UK. The available data shows that this issue has become significantly worse in recent years.

17 **Exhibit 2** sets out the number of delayed discharges experienced by the Health Board between April 2023 and February 2024, compared with other NHS bodies across Wales. These relate to patients who are considered clinically optimised but remain in a hospital bed 48 hours after the decision is made that they were well enough to leave hospital. As can be seen in the exhibit, the rate of delayed discharge is well below the all-Wales average and the lowest for six of the 11 months shown.

Exhibit 2: number of delayed discharges per 100,000 head of population (April 2023 – February 2024)



Source: Welsh Government

18 Since the pandemic, the way in which delayed discharges are measured has changed. No data on delayed discharges was formally reported between the period March 2020 and March 2023. Prior to the pandemic, delayed discharges were reported as 'delayed transfers of care' which were defined as those who continue to occupy a bed after the date on which the patient is declared to be ready to move on to the next stage of their care. This compares with the current method for counting delays which focuses on those who remain in a hospital bed 48 hours after being identified as clinically optimised.

19 Although not a direct comparison, in February 2020, the Health Board reported 30 delayed transfers of care. The position at the end of February 2024 of 238 delayed discharges equates to 13.7% of the Health Board's total bed capacity[3]. Whilst significant, this was the lowest percentage in Wales, with the all-Wales average being 17.9% (ranging between 13.7% and 31.3%).

20 The top five reasons for delayed discharges at the Health Board compared to the all-Wales position are set out in **Exhibit 3**, with the most common reasons being

[3] Based on general and acute bed availability data in July 2023, StatsWales website

awaiting completion of assessment by social care and awaiting social care allocation, both of which are higher than the all-Wales average. A full list of reasons for delays is set out in **Appendix 2**.

Exhibit 3: top 5 reasons for delayed discharges (February 2024)

Reason for delay	Percentage delayed	All-Wales average
Awaiting completion of assessment by social care	31.5	15.7
Awaiting social worker allocation	15.5	8.5
Awaiting completion of arrangements prior to placement	10.9	3.5
Awaiting joint assessment	4.6	9.0
Awaiting completion of clinical assessment (nursing/allied health professional/medical/pharmacy)	4.2	10.3

Source: Welsh Government

21 This data is also broken down to a local authority level, which is demonstrated in **Appendix 2**. Data shows that there are consistent challenges across the region, with awaiting completion of assessment by social care and social worker allocation the highest causes of delay in both local authority areas, accounting for 46% and 51% of all delays in Cardiff and Vale of Glamorgan respectively.

22 Bed days lost due to delayed discharges are a cause of significant financial inefficiency across Wales. For the region, data reported in February 2024 showed that the total number of delayed patients for that month accounted for 5,460 bed days. Based on a typical cost per bed day of £500,[4] this equates to costs in the region of £2.730 million. A total of 50,668 bed days were lost for the period April 2023 – February 2024. This is equivalent to £27.637 million for the year.

Impact on patient flow

23 We found that **whilst the Health Board's performance compares favourably on most urgent and emergency care performance metrics, there are indicators that onward flow through the hospital is challenging which is impacting admission of stroke patients and resulting in increased cancellation of planned care treatments.**

[4] Based on £500 per bed-day as set out in the NHS Confederation Briefing for the statement by the Minister for Finance and Local Government on the 2023-24 financial position

24 Delays in discharging patients from hospital have consequences for patient flow and, in particular, the ability for patients to access services when they need them. Beds being used by patients who no longer need them mean that they are not available for those who do, resulting, for example, in longer waits in emergency departments. This in turn impacts on the ability for ambulance crews to hand over patients and respond to 999 calls in the community.

25 **Appendix 3** sets out the region's performance across a range of urgent and emergency care performance indicators in comparison to the position across Wales since April 2022. In summary:

- the percentage of ambulance red calls responded to within eight minutes has been consistently better than the all-Wales position but has not reached the national target of 65% since July 2022 (**Exhibit 15**).
- the median amber response time is longer than the national target of 20 minutes, however, it is consistently better than the all-Wales average, except for January 2024 (**Exhibit 16**).
- the percentage of ambulance handovers within 15 minutes is broadly in line with the all-Wales average, but falls well short of the national target of 100% at around 20% (**Exhibit 17**).
- the percentage of ambulance handovers taking over one hour at the Health Board's major emergency department has improved dramatically, reducing from around 50% in August 2022 to 11% in January 2024. This is the best position in Wales by a significant margin, though it remains above the national target of zero (**Exhibit 18**)[5].
- the total number of hours lost following notification to handover over 15 minutes is significantly better than the all-Wales average, steadily reducing from 2,722 in August 2022 to 834 hours in January 2024 (**Exhibit 19**).
- once the patient is in the emergency department, the median time from arrival to triage has reduced and is consistently better than the all-Wales position at 19 minutes in January 2024 (**Exhibit 20**).
- the median time from arrival at an emergency department to assessment by a senior clinical decision maker has been better than the all-Wales average, with one exception in 2022, and has improved from 105 minutes in April 2022 to 59 minutes in January 2024 **(Exhibit 21)**.
- the percentage of patients seen within four hours in a major emergency department has fluctuated since April 2022 between 58% and 75%. Performance is better than the all-Wales average but remains below the national target of 95% **(Exhibit 22)**.

[5] The target for no patient handover to take longer than one hour was introduced as an additional metric by the Welsh Government within the NHS planning framework in 2023-24 as part of work to try and reduce the increasing trend of lost hours.

- the percentage of patients seen within 12 hours in a major emergency department is better than the all-Wales position: as of January 2024, these figures were 92%, just short of the national target of 100% **(Exhibit 23)**.
- the percentage of bed days accrued by people with a length of stay over 21 days was in line with the all-Wales average between April 2022 and April 2023 at between 55% and 65% **(Exhibit 24)**.

26 The Health Board's total bed capacity has fluctuated over recent years, with 1,779 total beds available in 2022-23, with just under half allocated to acute medicine (903). Bed occupancy in the acute medicine beds has been at 89.6%, compared with an optimal level of 85%. The Health Board is one of three health boards that does not have community hospital beds managed by GPs, however, it does have access to Health Board step down community hospital beds as well as Local Authority commissioned step down care home beds.

27 Pressure on available beds because of delayed discharges means that health boards are not always able to ensure that patients are placed on the best wards for their clinical needs. For example, health boards will usually hold vacant beds on stroke units to ensure that stroke patients have fast and direct access, enabling them to access stroke specialists and equipment.

28 Health boards have increasingly experienced difficulties in admitting stroke patients to a stroke ward, as problems with patient flow and bed availability mean that these beds have been needed for urgent non-stroke patients. Between April 2022 and April 2023, performance for the Health Board was volatile with the percentage of stroke patients with direct access to a stroke ward within four hours fluctuating between a low of 3.3% and a high of 54%. Since April 2023, performance has improved, with performance ranging between a high of 72.5% in June 2023, and a low of 43.5% in April 2024.

29 During 2022-23, 456 planned care admissions were cancelled due to the lack of an available ward bed in the Health Board. For the period 2023-24 up to and including February 2024, 579 planned care admissions were cancelled. This compares to 413 for the same period in 2022-23. This level of cancellation represents poor patient experience and risks the conditions of planned care patients further deteriorating while they wait for their treatment to be rescheduled.

What is impacting effective and timely flow of patients out of hospital?

30 This section sets out the issues impacting on effective discharge planning and the timely flow of patients out of hospital across the region.

31 We found that **the region is effectively supporting people to return home, but faces challenges due to social care capacity issues, inconsistent discharge policy application, and rising demand from an aging population.**

Volume and complexity of demand

32 We found that **rising age demographics and increasing physical and mental health needs are placing increasing demands on regional health and social care services.**

33 In the Cardiff and Vale region, people between the ages of 65 and 84 accounted for 14% of the population as of 2019, but that figure is expected to increase to 16.2% by 2039[6]. As people live for longer, there is a correlating increase in the numbers of people who live with multiple long-term conditions and complex health needs, and who will therefore need to rely on health and care services for support.

34 COVID-19 exacerbated this increase in complex demand. During the pandemic, demand for emergency departments declined rapidly, as people followed national advice only to access urgent and emergency care if truly needed, in order to protect core frontline services. In addition, families provided additional care and support to avoid their loved ones being admitted to hospital or long-term care out of fear of contracting COVID-19.

35 According to data gathered by the region, in 2017-18, 71.6% of older people living in the region rated their wellbeing as 'good' or 'very good' prior to the COVID-19 pandemic. This has since decreased and in 2022 stood at 52.8%. In addition, only 47.7% of older people in Cardiff and 50.2% in the Vale of Glamorgan reported that they live free from a limiting long-term illness. This inevitably means there will be a greater reliance on the region's health and social services than in previous years, including urgent and emergency care services. Those we spoke to during the fieldwork cited a specific increase in mental health demand since the beginning of the pandemic and data shows that within the region the number of older adults living with severe dementia is predicted to double by 2040[7].

Workforce capacity

36 We found that **there have been high levels of vacancies in social care which have had on impact on delays in discharging patients.**

37 Across Wales, the staff involved in discharge planning are increasingly finding their capacity stretched due to factors such as high vacancy rates and unplanned absence rates. Reduced numbers of staff lead either to a reliance on agency staff and/or to fewer permanent staff attempting to manage increasingly complex patients and organise the ongoing care they need for discharge. High usage of agency staff has inevitable impacts on continuity within the workforce.

38 Within the region, capacity issues have been greater within social care than in health services. As of March 2024, the Health Board was reporting very few vacancies as a percentage of its total establishment, with nursing and midwifery

[6] Cardiff and Vale Regional Partnership Board Joint Area Plan 2023-28 About – CAVRPB

[7] Cardiff and Vale Market Stability Report, 2022

vacancies at 2.4%, compared to 6.5% at an all-Wales level, and zero vacancies for medical staff. The unplanned absence rate for the Health Board in March 2024 was broadly in line with the all-Wales position at 5.9%, with the absence rate for nursing and midwifery at 6.9%, slightly below the all-Wales position of 7.1%. The medical unplanned absence rate was low at 1.4% compared to the all-Wales average of 2.2% figure. The use of agency staff accounted for 0.91% of the Health Board's total pay bill in March 2024, down from 3.8% in March 2023.

39 According to the most recent publicly published data, as of June 2023, both Cardiff Council and the Vale of Glamorgan Council were reporting high vacancies in adult social services, with the highest rate of vacancies in Cardiff at 39%[8]. In February 2024, the unplanned absence rate in adult social services was above the all-Wales position in Cardiff, but below in the Vale of Glamorgan, as shown in **Exhibit 4**. We have seen more recent data which indicates vacancies have reduced within the Vale of Glamorgan, supported through long-term agreements with agency contracts. Data on agency use has not been reported since June 2023, but up until that point, the use of agency staff in Cardiff Council was well above the all-Wales average at 11% (compared to 2% across Wales). The use of agency staff in the Vale of Glamorgan was at 3%.

Exhibit 4: percentage unplanned absences in adult social services (June 2023)

Local authority	Unplanned absence
Cardiff	7
Vale of Glamorgan	5
All-Wales average	**6.4**

Source: Welsh Government

40 Some of the staff challenges associated with social services correlate with the issues highlighted in **Exhibit 3**, where delays due to awaiting social care assessments or receiving a social worker allocation together accounted for 47% of delayed discharges across the region in February 2024. **Exhibit 5** sets out the extent to which adult social services in the region can meet demand for assessment.

[8] Cardiff 39%, Vale of Glamorgan 21%. No data has been made available since June 2023.

Exhibit 5: number of social care assessments completed and awaiting to be completed per 100,000 head of population (February 2024)

Local authority	Social care assessments completed	Adults waiting for a social care assessment	Percentage of adults waiting that are in hospital
Cardiff	116	60	28.4%
Vale of Glamorgan	153	63	38.2%
All-Wales average	**250**	**125**	**8.7%**

Source: Welsh Government

41 Both the number of completed assessments and the waiting lists for social care assessments are significantly less than the all-Wales average. In fact, data since November 2022 shows that Cardiff regularly had the lowest number of assessments completed per 100,000 head of population in Wales at 80 per month. The number of social care assessments completed in Cardiff for February 2024 was higher than usual. While waiting lists for social care assessments in the region have generally been below the all-Wales average, the waiting lists are almost half the level of monthly activity, which suggests there are potential pressures on capacity to meet demand. In addition, a significant percentage of the adults awaiting a social care assessment are those waiting in a hospital bed, with figures in this region among the highest in Wales.

42 We are aware that the region has been working to respond to its workforce challenges. A Pathways of Care Delays action plan in place for 2024-25 clearly demonstrates efforts to mitigate the delays in progressing assessments. Actions included screening referrals, streamlining the assessment process and additional supervision and accountability to ensure services are timely.

Care sector capacity

43 We found that **the region places a strategic emphasis on its domiciliary care services to support patients when they leave hospital and is currently successfully meeting that higher demand.**

44 Availability of home (domiciliary) care packages and long-term residential care home accommodation are a key cause of discharge delay across Wales. Within the Cardiff and Vale region, there is greater commitment to support people to return home with support than to place them into care homes. **Exhibit 6** sets out the number of adults receiving care sector support and the extent to which there are waits for provision. **Appendix 4** sets out waiting list performance for social are assessments and care packages since November 2022.

Exhibit 6: number of adults receiving (and waiting for) care packages and placements per 100,000 head of population (February 2024)

Local authority	Domiciliary care[9] in receipt (waits)	Reablement[10] in receipt (waits)	Long-term care home accommodation[11] receipt (waits)
Cardiff	807 (0)	44 (6)	317 (7)
Vale of Glamorgan	973 (13)	34 (2)	515 (3)
All-Wales average	**665 (34)**	**46 (9)**	**536 (11)**

Source: Welsh Government

45 The region appears to be managing the demand for supporting people to return home well. The exhibit shows the number of adults in receipt of domiciliary care in the region is significantly higher than the all-Wales average, whilst the numbers waiting for care are low. This correlates with data shown in **Exhibit 3**, that as of February 2024, awaiting start of a new care package accounted for only 4.2% of delayed discharges. The number of adults in receipt of reablement per 100,000 head of population is broadly in line with the all-Wales average and the number of adults in receipt of long-term care home accommodation per 100,000 head of population is mixed, with the Vale of Glamorgan in line with the average all-Wales figure while Cardiff consistently has the lowest figure in Wales. Waiting lists across all three means of ongoing support are lower in the region than at an all-Wales average.

46 **Exhibit 7** indicates the extent to which there are unfilled domiciliary hours, and the average number of hours provided per adult.

[9] Includes domiciliary care both provided and commissioned by local authorities.

[10] Includes reablement provided by local authorities.

[11] Includes long-term care home accommodation commissioned by local authorities.

Exhibit 7: unfilled domiciliary hours and average hours of domiciliary care provided per adult, per 100,000 head of population (February 2024)

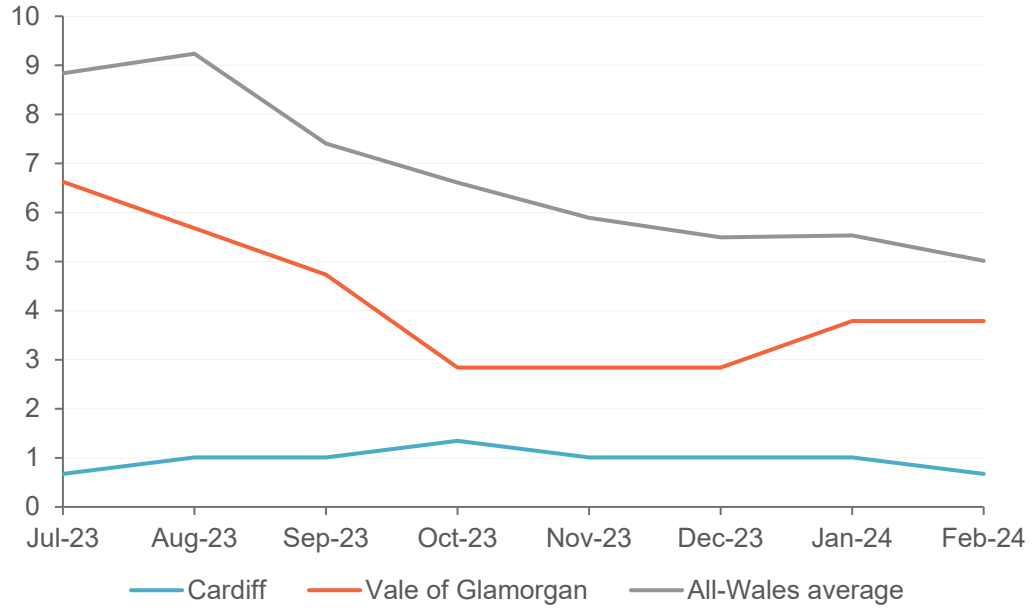
Local authority	Hours waiting to be filled	Average hours per adult
Cardiff	0	16.3
Vale of Glamorgan	160.4	15.7
All-Wales average	**352.6**	**13.2**

Source: Welsh Government

47 The number of domiciliary care hours waiting to be filled per 100,000 head of population in Cardiff has been at zero for ten of the past sixteen months and has been very low in the other six. The number of hours waiting to be filled within the Vale of Glamorgan has decreased significantly from nearly 2,000 in November 2022 to a low of 57 in January 2024 before rising again to 160 in February 2024. Both areas in February 2024 were significantly lower than the all-Wales average. The region also purposefully provides a higher number of domiciliary care support hours on average per person than at an all-Wales level. This again shows that, while the region relies heavily on domiciliary care, it is successfully able to deal with the current levels of demand.

48 **Exhibit 8** sets out the extent to which unplanned short-term care home accommodation is used across the region. Since November 2022, the region has had some of the lowest numbers of adults per 100,000 head of population in unplanned short-term care home accommodation in Wales. This is a result of management of the domiciliary care market in reducing the need for short-term care home placements

Exhibit 8: number of adults per 100,000 head of population in unplanned short-term care home accommodation for three or more months, with no end date (July 2023 – February 2024)



Source: Welsh Government

49 Whilst Cardiff is among the Council areas with the largest overall number of care home beds in Wales, as of July 2023, it had the lowest number of people per 100,000 head of population receiving care home provision. This, along with the fact there are generally low or no waiting lists for domiciliary care, means Cardiff Council does not rely on unplanned accommodation for a period of 3+ months in the same way as other regions and therefore fewer people are placed in unplanned temporary accommodation. The Vale of Glamorgan has significantly less care home beds than Cardiff and has a higher number of people placed in unplanned temporary accommodation for three or more months, although this is still consistently better than the all-Wales position per 100,000 head of population.

Discharge process

50 We found that **there is variation in adhering to the Health Board's discharge policy, with evidence of incomplete documentation.**

51 Awaiting joint assessment and completion of a clinical assessment by a health professional accounted for a much smaller proportion of discharge delays according to the data shown in **Exhibit 3**. However, our review found other health specific factors that lead to discharge delays.

52 Good discharge planning is reliant on good communication and co-ordination across different professional groups, with consideration of discharge as soon as a patient is presented to services. Good discharge planning is also facilitated by having clearly documented processes which are shared with all staff involved to promote understanding and awareness of the different roles in the discharge process.

53 The Health Board has a discharge policy. The discharge policy we reviewed was comprehensive and provided clarity on the various roles and responsibilities of team members to discharge patients. It promoted a co-ordinated multi-disciplinary team approach and highlighted the importance of good communication with the patient and/or their representatives. However, in our 2017 review, we recommended the Health Board ensure its upcoming revision of the policy involved patients and carers. While the policy was revised in 2020, it is not clear to what extent this revision was informed by collaboration with patients and carers. The policy was again due to be revised in 2023, but this has not yet happened.

54 An Internal Audit report in 2020 highlighted issues with adherence to the Health Board's discharge processes. The report found variation in its review of whether staff were adhering to the Health Board's process and highlighted instances where the process had not been applied correctly. Examples included patient discharge information leaflets not distributed, lack of up-to-date Predicted Dates of Discharge and incomplete discharge checklists.

55 The findings of the internal audit report in 2020 were mirrored in our hospital patient case note review. Our case note review analysed a sample of patient notes from October 2022 with a length of stay beyond 21 days. We found variable quality and completeness of discharge documentation between clinicians and wards. Some of the key findings included:

- no evidence of an expected date of discharge within 48 hours of admission in 14 of the 17 cases (82%) reviewed;
- lack of documentation for What Matters Conversations within any of the case notes reviewed, and under half of the case notes (47%) showed the family were involved and kept informed of the patient's care plans.
- evidence of a documented statement that the patient is clinically optimised for discharge in just over half (56%) of case notes; and
- evidence of regular discussion and review of discharge planning during ward rounds in 58% of the case notes.

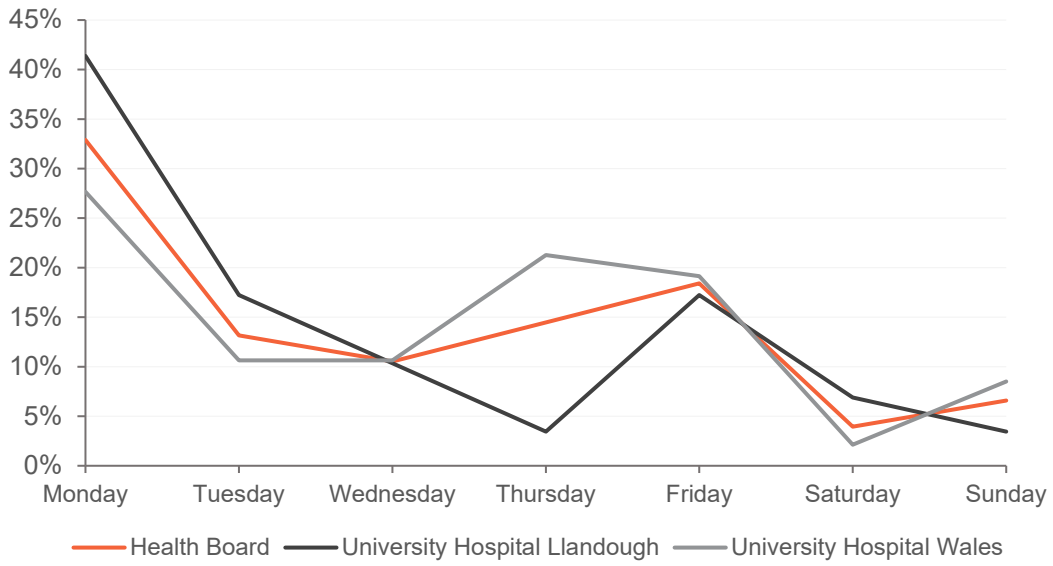
Whilst it is possible that arrangements may have changed since October 2022, the Health Board has not undertaken any recent audits to demonstrate improvements and it is likely that many of these issues remain.

56 In most of the case notes we reviewed, the main cause of delay in discharge was due to a delay in securing a social worker assessment. Many case notes showed that a referral was required for professionals including physiotherapists, occupational therapists, psychologists and dieticians. Positively, where referrals

where needed, we found helpful and complete documentation. However, once discharges were progressing, logistical arrangements were rarely described ie whether the patient required transport or whether their medications had been prepared.

57 We also noted that discharging patients from hospital remains an activity which largely takes place on weekdays, with very few (and mostly simple) discharges occurring on weekends, due to staff working patterns in both health and social care. Our data from October 2022 showed that only 3.9% of discharges occurred on Saturdays (**Exhibit 9**). During the week, discharges peak on a Monday across both sites, with a third of all discharges occurring on this day. This may be reflective of consultants' weekly working patterns at the time the data was captured (noting the Health Board's plans to introduce seven-day consultant working as described in **paragraph 71**). It may also reflect the availability of services to support discharge over the weekend.

Exhibit 9: day of discharge of all patients discharged from acute hospital sites in October 2022, as a percentage of total discharges[12]



Source: Audit Wales analysis

58 We were told that there are different discharge processes in place for patients from Cardiff and Vale of Glamorgan, such as the single points of contact services. We heard during our fieldwork that staff within the Health Board are not always aware of differences between social services' processes, which can lead to delay. Staff

[12] Excludes patients who died.

also spoke of a culture of risk aversion, whereby staff are reluctant to discharge patients because they fear the patient may not cope as well at home. Whilst staff may be acting out of kindness, they may not be acting in a patient's best interest. Keeping patients in hospital for longer than they clinically need has a negative impact on patient experience and outcome, as well as broader patient flow within the hospital. While many we spoke to recognised the negative impact of delayed discharges on the independence and wellbeing of patients, there is a continued reluctance to take measured risks and to recognise the significant knock-on impact delayed discharges have on patient flow and the wider system.

59 In 2018, the Welsh Government introduced the Discharge to Recover then Assess (D2RA) model, which is designed to support people to recover at home before being assessed for any ongoing need, thereby reducing length of stay in hospital. Implementation of the model was accelerated during the pandemic, and the Welsh Government has subsequently supported regions with additional monies to embed D2RA further, with updated national guidance being issued in December 2023. While staff we spoke to during our fieldwork demonstrated an awareness of the model and its principles, we found no references to D2RA within the discharge policy we reviewed.

What action is being taken?

60 This section considers the actions being taken by the statutory organisations, including through the Regional Partnership Board to improve the flow of patients out of hospital.

Strategic and operational plans

61 We found that **partners demonstrate a clear focus on jointly developed strategic and operational planning to improve patient discharge**

62 We reviewed relevant health board and local authority plans and found that plans in the region reflect a good understanding of the challenges affecting the flow of patients out of hospital. Plans also reflect the commitment of partners to resolve some of the key challenges related to flow such as workforce gaps. Plans, including the 2023 Joint Area Plan are informed by data and demand projections and reflect key Welsh Government planning requirements, including the six goals for urgent and emergency care[13].

63 The Health Board's delivery plan for the six goals for urgent and emergency care 2024-25 sets out existing and new initiatives to support delivery of the six goals programme. Our review found it to be a comprehensive and well-set out plan. The

[13] Introduced in 2021, the national six goals for urgent and emergency care programme contains two goals that are directly linked to improving discharge: 'goal five – optimal hospital care and discharge practice from the point of admission', and 'goal six: home first approach and reduce risk of readmission'.

Health Board has consolidated the Welsh Government six goals for urgent and emergency care into four workstreams, the fourth of which is optimising hospital flow and discharge. The action plan identifies ambitions to improve discharge arrangements through measures such as seven-day working for consultants, a reshaped frailty pathway and expansion of community services to enable a pull of patients from secondary care.

64 Partners in the region have also developed a joint action plan for Pathways of Care Delays. This action plan clearly sets out individual actions, responsible officers, timescales and progress updates. The version we reviewed, of January 2024, showed good progress across most actions, with particular success in terms of arrangements for regular engagement between partners to review and discuss challenges and improvements. However, we did note that a significant number of actions largely related to the establishment of meetings, with less focus on the impact and outcomes of such engagement work.

65 The region recognises that a key shared challenge is recruiting qualified community-based staff to support hospital discharge, including carers and occupational therapists. In 2022, the region undertook a Strengths, Challenges, Opportunities, Threats (SCOT) analysis to inform its advertising campaign, titled 'Join our Caring Community' which is designed to utilise several methods to attract applicants to roles as they appear. Cardiff Council are also working to address the shortages within domiciliary care services by launching their own Cardiff Cares Academy to train people, as well as creating a 'Grow Your Own' programme which is a pathway to becoming a qualified carer.

66 The Health Board's winter plan for 2022-23 was developed with partners across the region. The plan was informed by an internal demand and capacity exercise conducted by the Health Board to compare the available bed base against best, worst and pre-COVID average scenarios. The plan predicted a potential bed gap during peak pressures of 152 beds. Partners then sought to mitigate this gap via initiatives described within a supporting joint action plan between the Health Board and the two local authorities. The actions include further employment of social workers, overseas recruitment and sponsorship, and increasing bed capacity and step-down facilities, including the Lakeside facility[14]. RPB papers from 2023 and 2024 show that these projects were successful in mitigating the challenges of winter pressures, with the success of initiatives in 2022 laying a good foundation for further success in winter 2023.

[14] https://cavuhb.nhs.wales/files/board-and-committees/quality-safety-and-patient-experience-committee-2021-22/241c-appendix-3-final-lakeside-wing-uhw-announced-scrutiny-visit-report1/

Partnership working

67 We found that **there is clear evidence of partnership working both strategically and operationally within the region, which is leading to positive change.**

68 At a strategic level, there is evidence of regular engagement and partnership working between the Health Board and the two local authorities. The Health Board Chief Executive Officer and the Directors of Social Services attend monthly Strategic Leadership Group (SLG) meetings and bi-monthly Regional Partnership Board meetings. Our observations of meetings reflected constructive discussions taking place at these forums, with clear evidence of collaboration on items and good discussion including constructive challenge.

69 Operationally, staff we spoke to said they had witnessed a culture shift during 2022 between health and social care staff where they now saw each other as working towards a common goal. This has led to a much-reduced tendency to revert to a blame culture where another professional is deemed the cause of a delay.

70 Partners invest their time heavily in facilitating timely flow and we observed a range of operational meetings including ward rounds, site manager meetings and DTOC meetings which include a wide range of professionals. There are also regular meetings between the Health Board and the local authorities to escalate and manage delayed discharges.

71 The Trusted Assessor Model was first established as part of the COVID-19 hospital discharge service requirements set out by the Welsh Government in 2020. Trusted Assessor refers to someone acting on behalf of and with the permission of multiple organisations carrying out an assessment of health and/or social care needs in a variety of health or social care settings. The model has the potential to support a more efficient and timely service response. Due to slow progress in implementing the model across Wales, in February 2023, the Welsh Government set a requirement for regions to review and implement a Trusted Assessor Action Plan. The region reports good progress against its action plan, with increasing numbers of occupational therapist posts supporting trusted assessment.

72 A key action within the Health Board's six goals plan for 2024-25 included the pursuit of seven-day working for consultants. Several of those we spoke to discussed the challenges in facilitating weekend discharges during our fieldwork, as discussed in **paragraph 58**. While its positive to note that the Health Board is taking action to address this, it is likely that improvements will be limited unless seven-day working is pursued with other professionals and undertaken in collaboration with partners. For example, if care homes or domiciliary care are unable to accommodate patient discharge over weekends the initiative may fail to achieve the full potential impact.

Operational structures

73 We found that **operational structures across the region and within the Health Board are providing a positive focus on patient flow.**

74 The Health Board's four workstreams for the six goals for urgent and emergency care are managed by groups which meet monthly to monitor the delivery of plans. Effective senior ownership of each workstream is secured via allocated clinical and operational leads. The workstreams report into the Cardiff and Vale Six Goals Delivery Board, which is chaired by the Health Board's Chief Operating Officer, which in turn reports into the Health Board's Senior Leadership Board. These arrangements demonstrate good senior ownership of the six goals agenda to drive change.

75 At a regional level, the activity mostly associated with improving flow out of hospital is overseen by the @Home Delivery Programme Board within the Regional Partnership Board structure. The @Home Delivery Programme contains a good mix of health and social care colleagues. Our meeting observation found evidence of effective collaboration and positive engagement between members.

76 The Programme Board leads the strategic development and oversight of regional programmes and their supporting projects. The Programme Board reports to the RPB's Strategic Leadership Group (SLG), which in turn reports to the RPB. We found that membership of both the SLG and RPB included an appropriate split of representatives and seniority from partners, showing a clear focus and intent of partners to engage with and support improvements to long-standing challenges, including those relating to flow out of hospital. This was demonstrated in the partnership working to respond to the Welsh Government 1,000 bed challenge[15]. The Welsh Government requirement was for the region to establish 163 of the 1,000 beds or equivalent services by the end of March 2023. Welsh Government reports show that the region identified 112 beds or equivalent services. This largely mirrors the picture across Wales, which saw many regions make progress but ultimately fail to achieve their notional target due to factors such as staff shortages.

Information sharing

77 We found that **the Health Board is further strengthening its processes for collating and analysing information, including revising discharge forms and developing digital solutions to support effective discharge**

78 Professionals within and across organisations will typically be required to share information about the patient to facilitate appropriate discharge arrangements and ongoing care, especially where the patient has more complex needs. During our

[15] In July 2022, the Health and Social Care Minister set a challenge for Health Boards and Local Authorities to establish an additional 1,000 bed spaces or their equivalents to support timely discharge: https://www.gov.wales/written-statement-six-goals-urgent-and-emergency-care-programme-update

fieldwork, we found that arrangements for collecting information generally work well, with a good range of data available to staff.

79 However, challenges occur because of the patient data needed to support effective discharge being held in several IT systems. In addition, we heard that capacity constraints mean staff find it difficult to keep electronic systems up to date which can mean patients ready for discharge are not identified as early as possible. Recognising these challenges, the Health Board is rolling out a system called STAMP[16] across its wards. STAMP is a digital system for monitoring and tracking patients to enable health staff to understand a patient's status in real-time. It automates the pulling of information from various sources to free up the time of staff. The Health Board had also commissioned work from data analysis agency, Lightfoot, which was providing helpful insights into existing data.

80 During our fieldwork, staff also told us that poor referral paperwork means social services receive unhelpful or inaccurate information about a patient's needs. The Health Board had recognised weaknesses in the documentation and was planning to develop a new referral form to provide better quality information regarding patients' needs.

Use of funding

81 We found that **the region demonstrates strategic planning in its use of RIF and takes care to evaluate performance and measure outcomes for patients.**

82 The region makes use of the Health and Social Care Regional Integration Fund (RIF) to support schemes aimed at improving discharge planning. The RIF is a Welsh Government five-year fund to deliver a programme of change from April 2022 to March 2027. The aim of the fund is to establish and mainstream at least six new national models of integrated care to provide a seamless and effective service for the people of Wales. Two contain a clear link to improving flow out of hospital for patients, namely: Home from Hospital Services; and Accommodation Based Solutions.

83 There is a clear expectation within the RIF guidance that partners 'match fund' projects up to 50% by the end of year 5, with the Welsh Government funding for each project tapering each year to allow for successful projects to become business as usual. However, due to the financial pressures that the NHS is currently facing, this expectation has been relaxed.

84 The region received £19.2 million of RIF funding in 2022-23 and £19.4 million in 2023-24. About two-fifths of the allocation is dedicated to its @Home Programme which sits under the Ageing Well priority of the RPB and supports the delivery of the national Home from Hospital Services model. The @Home Programme brings together six projects to enable older people to access the support they need, when and where they need it. In 2023-24, these included community support in hospital

[16] STAMP: System for Tracking and Managing Patients

to support patient discharge and establishment of an MDT cluster approach including social discharge follow-up. There is regular oversight of the @Home Programme through update reports which set out how patients are accessing the services provided.

85 The region submits financial information on how it is managing the RIF to the Welsh Government each quarter. For 2023-24, the RPB identified a forecast overcommitment of the RIF of circa £1.8 million at the beginning of the financial year. This was due to agreed expenditure to sustain the additional capacity brought in as part of the 1,000-bed challenge to create additional step-down capacity during winter 2022-23. However, a quarterly finance report from September 2023 shows that several projects were underspending due to vacancies or delayed recruitment. During our fieldwork we heard that it often takes longer to establish a project once it has been approved, including time to recruit, which can cause delays. The report also shows that partners in the region had committed £11.7 million match-funding, with £2.6 million for schemes within the Home from Hospital model.

86 The RPB's Annual Reports in 2022-23 and 2023-24 provide data and case studies on how the @Home Programme has benefited patients, including by providing access to intermediate care services to over 6,000 patients and achieving 70% of referrals to its 'Hospital to Home' project triaged within one day. The region also developed a case study report in 2022-23 which demonstrated the real impact of projects on the patients that received the funded services.

Scrutiny and assurance

87 We found that **there is reasonable scrutiny of issues relating to discharge planning within each partner organisation.**

88 We reviewed the level of information that partners' committees, Board and Cabinet receive in relation to flow out of hospital. The Health Board receives regular performance and risk reports which provide an insight into improvements related to patient flow via the Board and its committees. The Health Board demonstrates a focus on monitoring performance relating to urgent and emergency care services, and specifically patient flow through those services. The Board and the Finance Committee regularly monitor metrics including the following:

- median emergency response time to amber calls;
- median time from arrival at an emergency department to assessment by a senior clinical decision maker (minutes)
- number of ambulance patient handovers over one hour;
- patients waiting over 24 hours in the Emergency Department;
- attendances at Same Day Emergency Care units;
- length of stay for patients in acute beds; and
- pathways of care delays.

89 Performance reports clearly demonstrate how performance compares to targets, including ministerial priorities or the Health Board's annual plan commitments, using data and analysis to identify trends. The Finance Committee also periodically provides a focus on areas relevant to patient flow, such as in November 2023 when it received a report on length of stay, and in September 2023 when it received an overview of the financial performance of the RIF and the funded initiatives for 2023-24. The Health Board also takes steps to ensure the Board are informed of progress relating to the six goals for urgent and emergency care programme, including a comprehensive presentation at its Board Development session in February 2024. There is a clear focus on impact within reports using data and trends compared to clearly defined targets.

90 In addition, the Board and the Quality, Safety and Experience Committee monitors the corporate risk associated with patient flow. The second corporate risk listed on the Health Board's register relates to patient harm due to overcrowding in the 'Emergency and Acute Medicine footprint' resulting in 'the inability to provide and maintain key quality standards'. Current actions have reduced the risk score from the maximum of 25 down to 20, but it is yet to reach the target risk score of 15.

91 Both local authorities also demonstrate a focus on issues which relate to patient flow. For example, the Cardiff Adult Social Services Scrutiny Committee regularly scrutinises performance reports. Minutes from meetings evidence scrutiny with a strong focus on the social care workforce, considering capacity, recruitment, the Trusted Assessor Model and levels of sickness absence and vacancies. The committee receives a quarterly performance report which includes a range of metrics such as the number of people in residential care aged 65 or over per 100,000 population, average number of days between referral and start of package in domiciliary care, longest time between referral and start of package in domiciliary care (in days) and the average number of people waiting for domiciliary care at month-end. The performance report also includes a broader section on hospital discharge, tracking packages of care delays and the reasons for delays as well as the percentage of clinically optimised people assigned to a D2RA pathway within 72 hours of triage.

92 The Vale of Glamorgan Council's Healthy Living and Social Care Scrutiny Committee also monitors key metrics such as the number of adults waiting for domiciliary care and waiting for a social care needs assessment. The Council's Annual Delivery Plan sets out to reduce waiting list for domiciliary care packages including discharges, which they reduced to zero at the end of year for 2023-24. In addition, each January, the Council receives an update on the work of the RPB including use of the RIF, winter planning and the broader RPB work programme. However, there are no risks on either of the local authorities' risk registers relating to adult social services or hospital flow.

93 The RPB receives regular updates on RIF progress and periodic papers on key priority areas but does not receive regular operational performance reports. Consideration of performance reports would be valuable in understanding the impact of RIF activities on addressing long-standing performance challenges.

What more can be done?

94 There is a clear recognition by regional partners of the problems associated with discharge and a desire to sort them out aided by strategies and operational plans, and the use of funding targeted schemes. Collectively, this approach appears to be driving sustainable improvement in the overall position. Our work has found that there are several further actions that could be taken which would further help improve timely and effective flow out of hospital across the region and reduce some of the challenges currently being experienced by the health and social care system. These actions are explored in the following exhibit and align with the recommendations that are set out earlier in the report.

Exhibit 10: further actions for partners to help tackle the challenges for patient flow out of hospital

Improving compliance with policies and guidance	A more consistent application of intended discharge processes will be assisted by staff having access to up-to-date **jointly agreed guidance** which clearly sets out roles and responsibilities, and expectations around when and how staff should share information. In addition, having a **regular cycle of audit** would allow partners to assess the effectiveness and consistency of the application of discharge policies and guidance.
Improving the quality of information	Having **clear and comprehensive information** within patient case-notes which sets out the actions being taken to support discharge, enables a clearer understanding of what is happening with a patient and supports effective discharge planning by all professionals involved in the care of patients whilst in hospital.
Maximising weekend discharges	Developing **seven-day services** supports the discharge of patients over the weekend, reducing unnecessary stays in hospital.
Maximising the use of the Regional Integration Fund	Regularly considering **operational performance** at a regional level enables more effective decision making across partners when considering how best to use the regional funding.

Appendix 1

Audit methods

Exhibit 11 sets out the methods we used to deliver this work. Our evidence is limited to the information drawn from these methods.

Exhibit 11: audit methods

Element of audit methods	Description
Documents	We reviewed a range of documents, including: • Board, Cabinet, and committee papers • Updates on the six goals programme and urgent and emergency care to committees • Operational and strategic plans relating to urgent and emergency care • RPB papers, including case studies • Discharge procedure • Corporate risk registers
Interviews	We interviewed the following: • Director of Adults' Housing and Communities, Cardiff; • Senior Nurse Integrated Discharge; CVUHB • Director of Social Services, Vale of Glamorgan; • Head of Adult Services and Vale Alliance; • Director of Social Services Adults, Cardiff; • Operational Manager Adults' Community Services, Cardiff and Operational Manager Independent Living Services, Cardiff; • Managing Director Acute Services; CVUHB • Head of Operations Patient Flow and Site Services; CVUHB • Head of Integrated Care; CVUHB • Service Improvement Programme Manager; CVUHB • Chief Operating Officer; CVUHB • RPB Lead; • Director of Operations; CVUHB • Deputy Director of Nursing; CVUHB • Executive Lead of Strategic Planning; CVUHB • Community Health Council Chief Officer; and • Programme Manager for Six Goals. CVUHB

Element of audit methods	Description
Observations	We observed the following meeting(s): • Bed meeting, University Hospital of Wales • Strategic Leadership Group • @Home Programme Board • Regional Integrated Management Team We also observed the following individual: • Discharge Coordinator
Data analysis	We analysed the following national data: • monthly social services dataset submitted to the Welsh Government; • monthly delayed discharges dataset submitted to the NHS Executive; • StatsWales data; and • ambulance service indicators. We also analysed data provided by the Health Board relating to all emergency medicine patients discharged in October 2022 with a length of stay greater than 21 days (excluding those who died).
Focus groups	We undertook focus groups with social workers from each of the local authority areas.
Case note review	We reviewed a sample of 20 case notes relating to emergency medicine patients discharged in October 2022 with a length of stay greater than 21 days (excluding those who died).

Appendix 2

Reasons for delayed discharges

The following exhibit sets out the reasons for delayed discharges in the Health Board compared to the all-Wales position.

Exhibit 12: reasons for delayed discharges as a percentage of all delays (February 2024)

Reason for delay	Percentage delayed	All-Wales average
Awaiting completion of assessment by social care	31.5	15.7
Awaiting social worker allocation	15.5	8.5
Awaiting completion of arrangements prior to placement	10.9	3.5
Awaiting joint assessment	4.6	9.0
Awaiting completion of clinical assessment (nursing /allied health professionals /medical/pharmacy)	4.2	10.3
Awaiting start of new home care package	4.2	8.0
Patient/family refusing to move to next stage of care/discharge	3.4	1.6
Awaiting transfer to intermediate care bedded facility	2.9	4.0
Court of protection delays	2.9	0.6
No suitable abode	2.1	2.3
Awaiting extra care/supported living availability	1.7	0.9
Awaiting nursing care home manager to visit and assess (Standard 3 residential)	1.7	2.1
Awaiting restart of previous home care package	1.7	0.5
Homeless	1.7	0.9
Awaiting continuing healthcare (CHC) assessment	1.3	1.7
Mental capacity	1.3	2.1
Patient/family choice related issues	1.3	0.9

Source: Welsh Government

Note: where the reasons for delay relate to two or less patients, these have been excluded to minimise any risk of identifying individual patients.

Top five reasons for delayed discharges by local authority

The following exhibits set out the top five reasons for delayed discharges for each of the local authorities compared to the Health Board wide and all-Wales position.

Exhibit 13: top five reasons for delayed discharges as a percentage of all delays (February 2024) – Cardiff

Reason for delay	Percentage delayed	Health Board average	All-Wales average
Awaiting completion of assessment by social care	30.9	31.5	15.7
Awaiting social worker allocation	15.4	15.5	8.5
Awaiting completion of arrangements prior to placement	9.9	10.9	3.5
Awaiting completion of clinical assessment (nursing /allied health professionals /medical /pharmacy)	4.9	4.2	10.3
Awaiting start of a new home care package	4.3	4.2	8.0

Source: Welsh Government

Exhibit 14: top five reasons for delayed discharges as a percentage of all delays (February 2024) – Vale of Glamorgan

Reason for delay	Percentage delayed	Health Board average	All-Wales average
Awaiting completion of assessment by social care	35.1	31.5	15.7
Awaiting social worker allocation	16.2	15.5	8.5
Awaiting completion of arrangements prior to placement	12.2	10.9	3.5
Awaiting joint assessment	6.8	4.6	9.0
Awaiting start of a new home care package	5.4	4.2	8.0

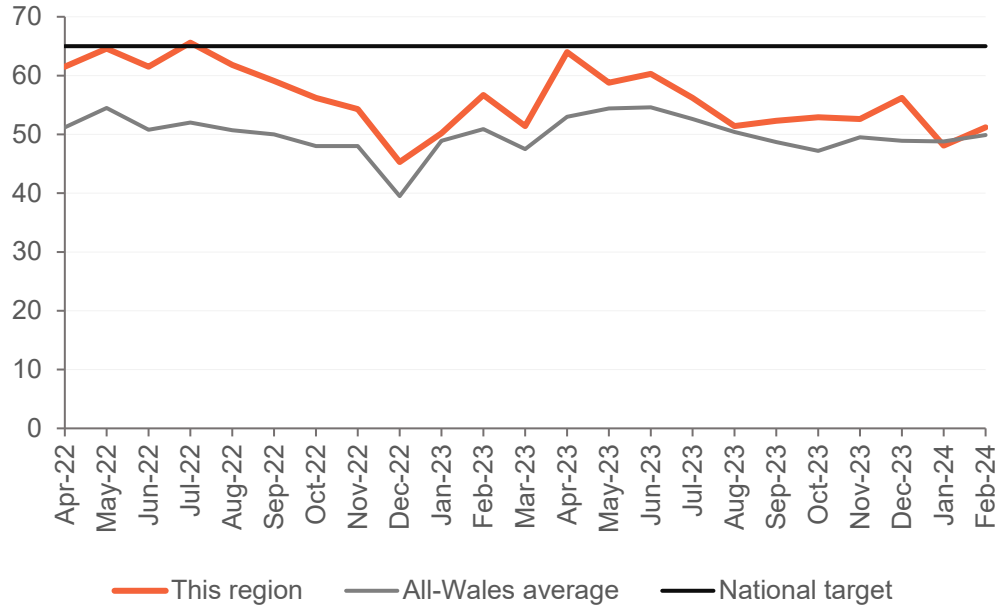
Source: Welsh Government

Appendix 3

Urgent and emergency care performance

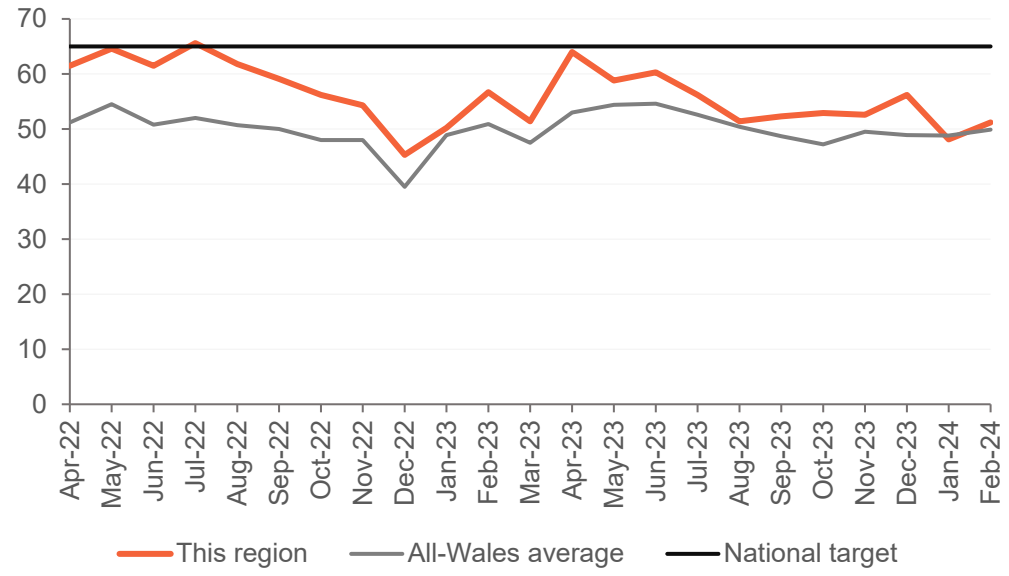
The following exhibits set out the region's performance across a range of urgent and emergency care performance indicators in comparison to the position across Wales since April 2022.

Exhibit 15: percentage of emergency responses to red calls arriving within (up to and including) eight minutes – national target of 65%



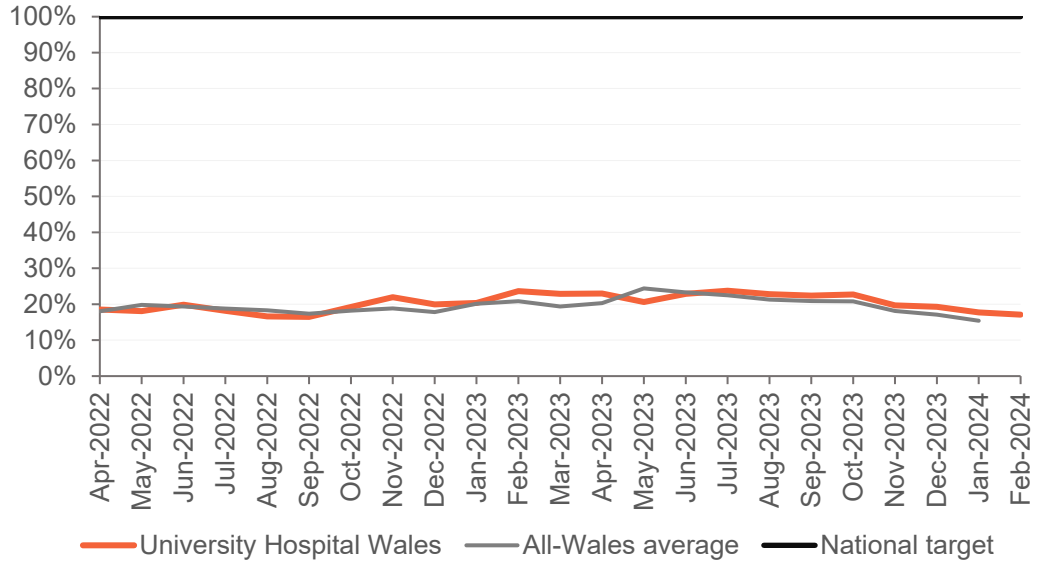
Source: StatsWales

Exhibit 16: median response time for amber calls (minutes) – 50th percentile – national target of 20 minutes



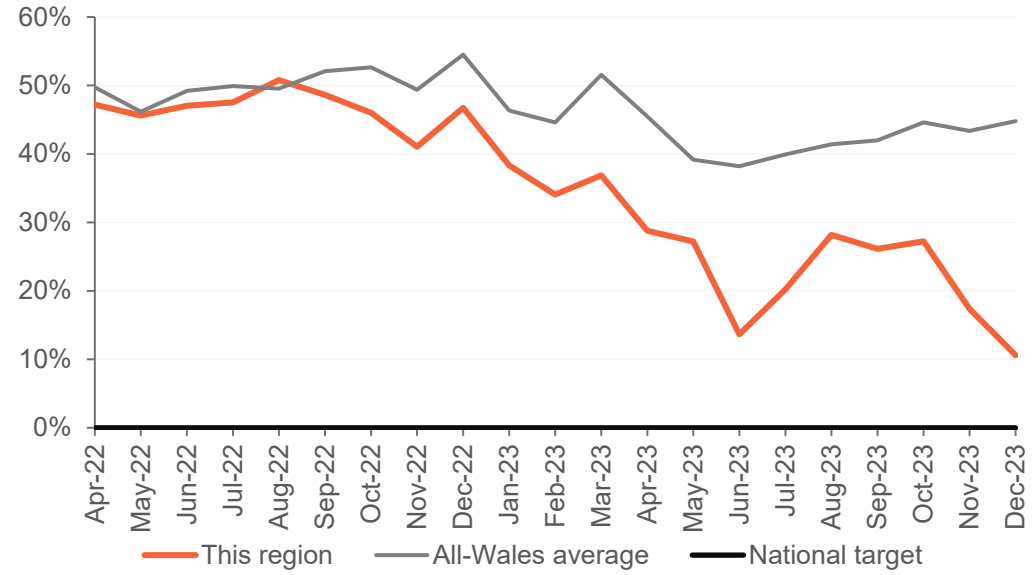
Source: Ambulance Services Indicators

Exhibit 17: percentage of ambulance handovers within 15 minutes at a major emergency department – national target of 100%



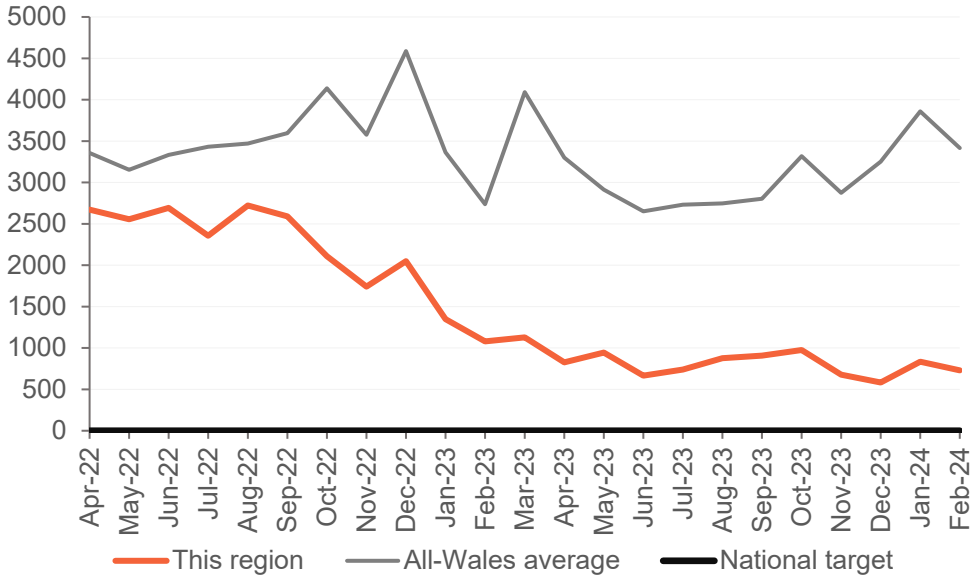
Source: Ambulance Services Indicators

Exhibit 18: percentage of ambulance handovers over one hour – national target of zero



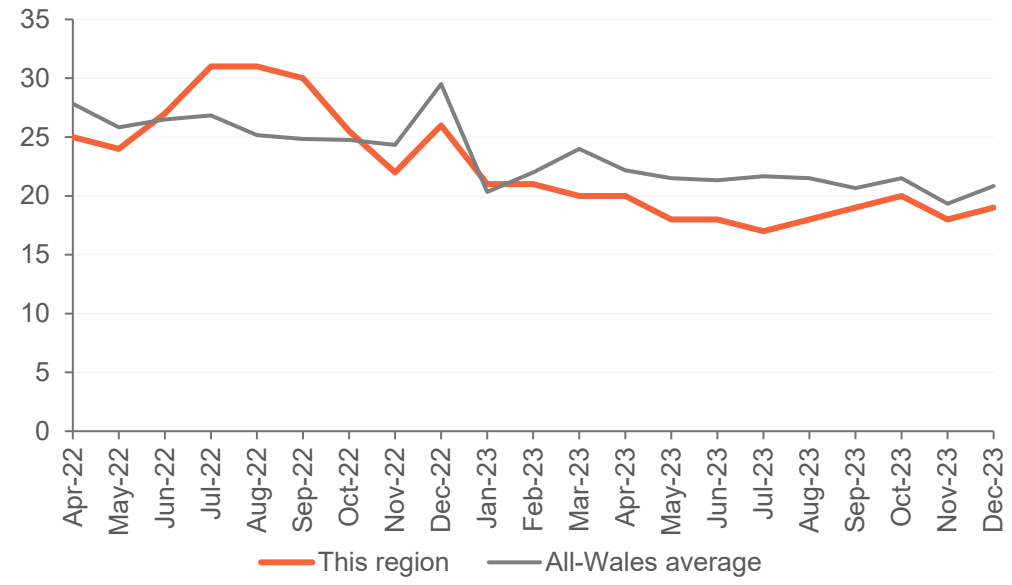
Source: Ambulance Services Indicators

Exhibit 19: total number of hours lost following notification to handover over 15 minutes



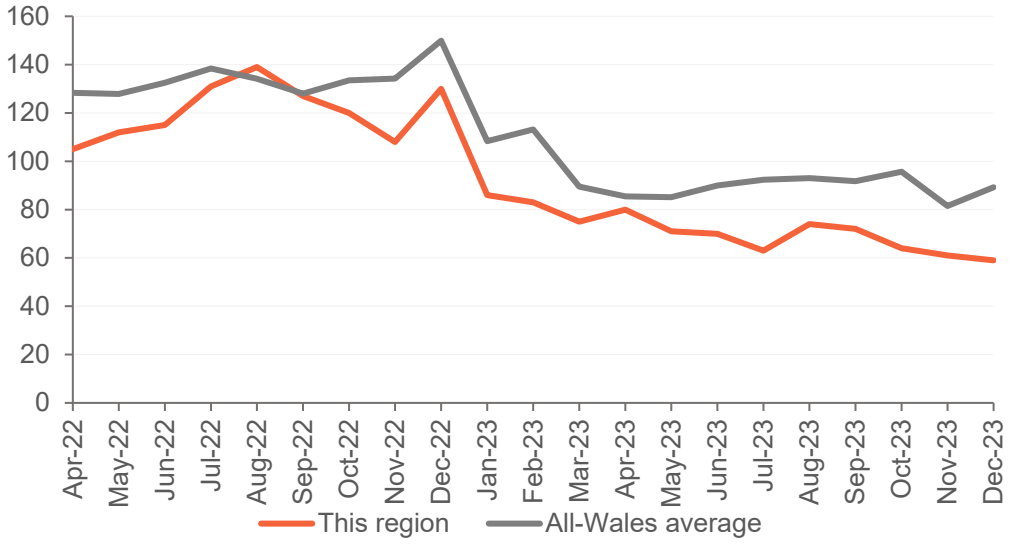
Source: Ambulance Services Indicators

Exhibit 20: median time (minutes) from arrival at an emergency department to triage by a clinician) – national target of 12-month reduction



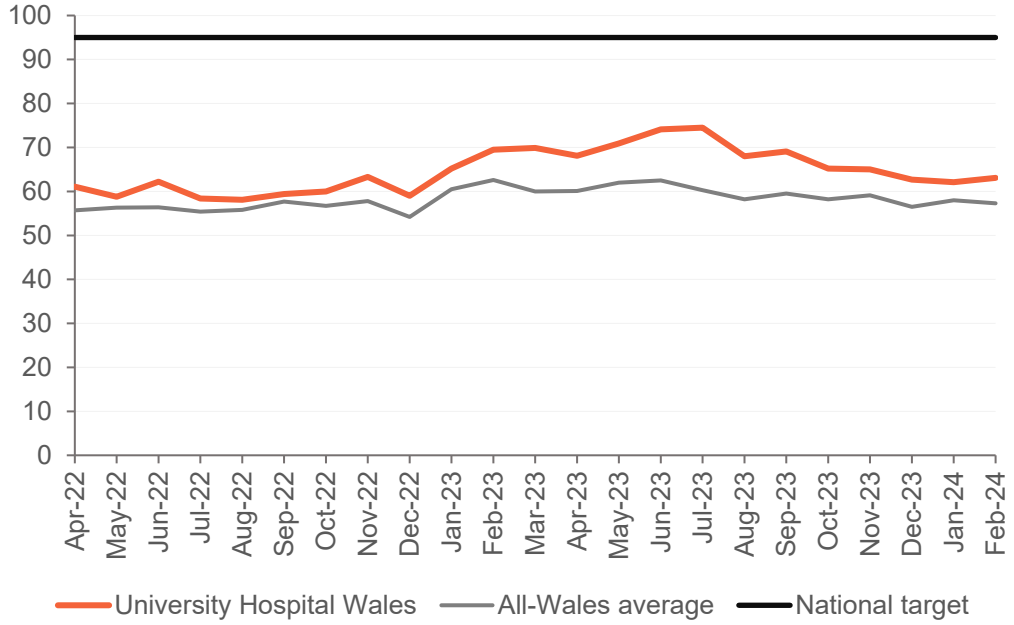
Source: Health Board performance reports

Exhibit 21: median time (minutes) from arrival at an emergency department to assessment by senior clinical decision maker – national target of 12-month reduction



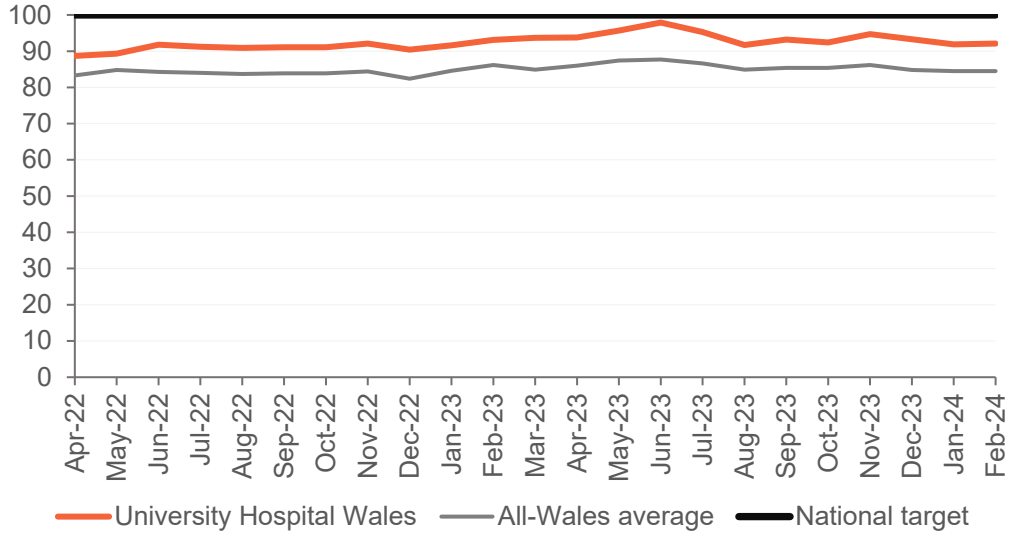
Source: Health Board performance reports

Exhibit 22: percentage of patients spending less than four hours in a major emergency department – national target of 95%



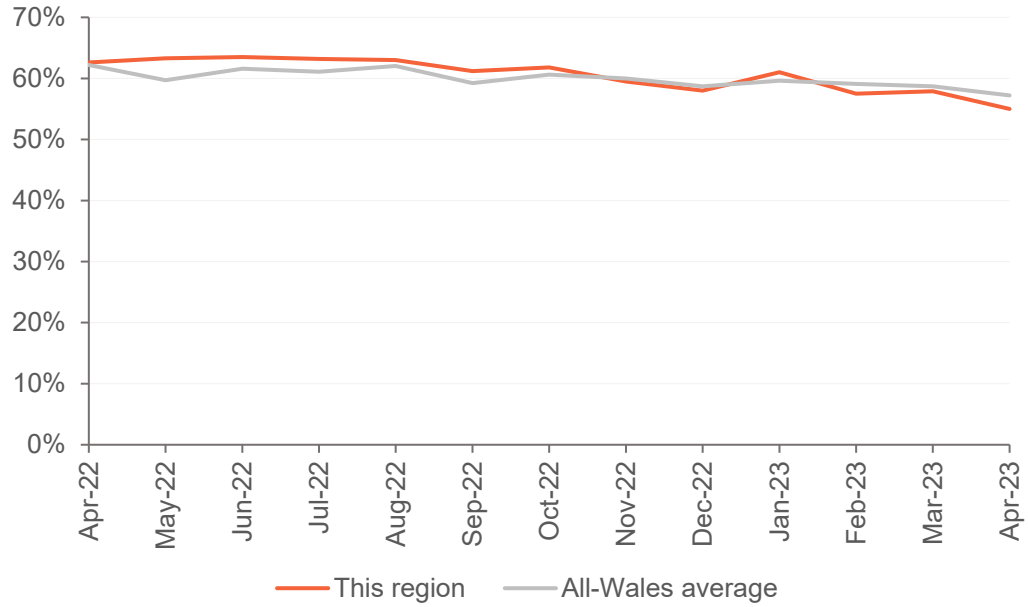
Source: StatsWales

Exhibit 23: percentage of patients spending less than 12 hours in a major emergency department – national target of 100%



Source: StatsWales

Exhibit 24: percentage of total emergency bed days accrued by people with a length of stay over 21 days – national target of 12-month reduction



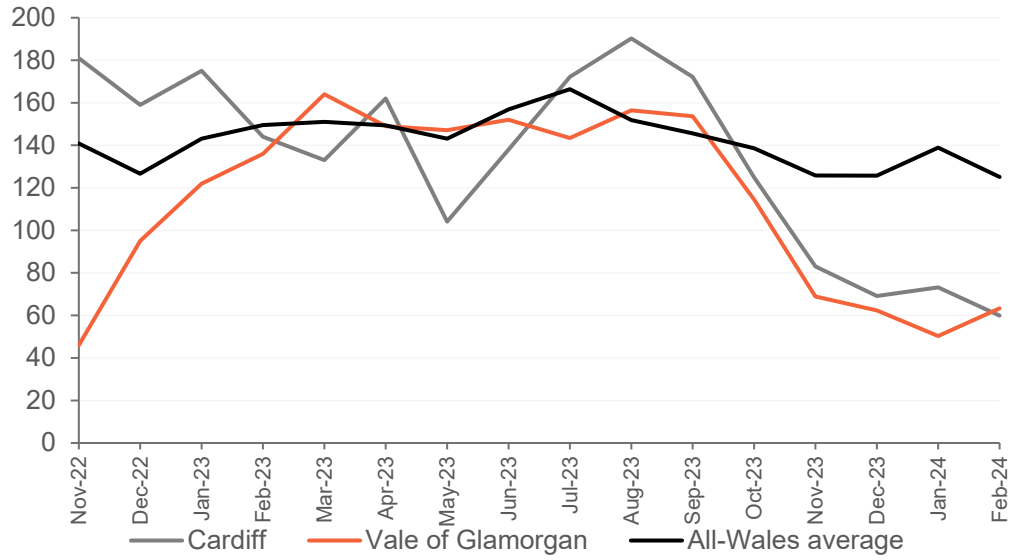
Source: Health Board performance reports

Appendix 4

Waits for social care assessments and care packages

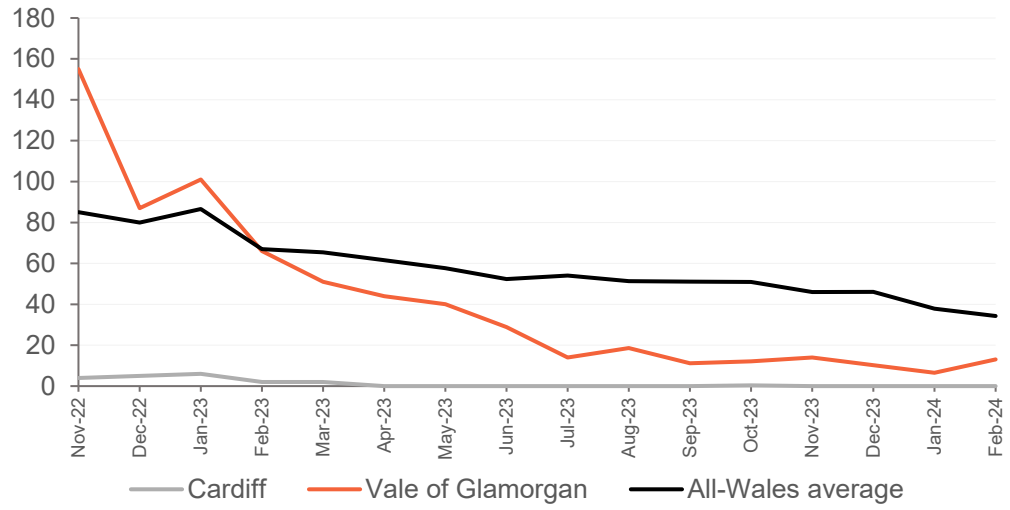
The following exhibits set out the region's waiting performance for social care assessment and receipt of a range of care packages in comparison to the position across Wales since November 2022.

Exhibit 25: number of adults waiting for a social care assessment (per 100,000 head of population)



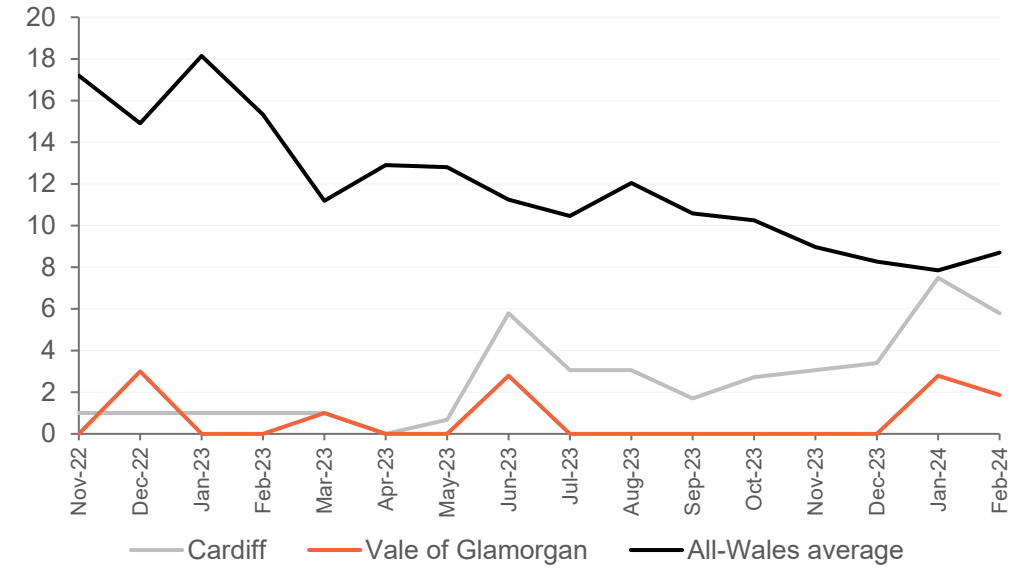
Source: Welsh Government

Exhibit 26: number of adults waiting for domiciliary care (per 100,000 head of population)



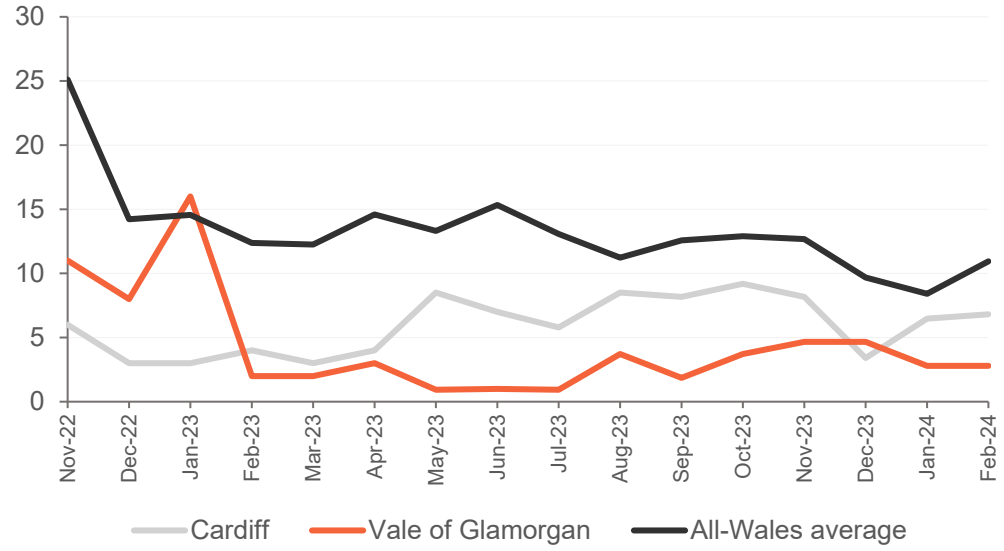
Source: Welsh Government

Exhibit 27: number of adults waiting for reablement (per 100,000 head of population)



Source: Welsh Government

Exhibit 28: number of adults waiting for long-term care home accommodation (per 100,000 head of population)



Source: Welsh Government

Appendix 5

Combined management response to audit recommendations

Exhibit 29: combined management response

Ref	Recommendation	Organisational response	Completion date	Responsible officer
R1	To help inform discussions around discharge, the local authorities should capture the risks associated with social care capacity on the provision of services at a local and regional level, including the impact on patient flow out of hospital.	i. Capacity is monitored and reported to the Welsh Government on a monthly basis via two routes: • Social care checkpoint data which has a RAG rating • PoCD regional meetings which relate directly to hospital flow Issues can then be escalated through local or regional governance. ii. Local Authorities have existing internal risk monitoring and management arrangements. iii. The RPB undertakes a five-yearly Market Stability Report to inform care commissioners of social care market sufficiency and stability. A Regional Commissioning Board is in place to	Already in place	Local Authority Heads of Adult Services

Ref	Recommendation	Organisational response	Completion date	Responsible officer
		monitor capacity and address identified issues.		
R2	The Health Board, working with local authorities, should update its discharge policy and associated policies, including the choice of accommodation policy, to provide clarity to all staff on how the discharge planning process should work across the region. This should be based on the national guidance issued in December 2023, set out clearly defined roles and responsibilities, and expectations, and reflect the Discharge to Recover then Assess model. The process for updating the policy should include patients and carers.	i. The Health Board is developing a new discharge policy to include the key elements from the most recent national discharge guidance in September 2024. The policy is being developed with input from local authorities. ii. The policy will be reviewed by the partnership governance arrangements through the Strategic Leadership Group. iii. Advice and support will be sought from Llais on involvement of patients and carers.	April 2025	Head of Integrated Discharge
R3	The Health Board should embed a regular cycle of audit to assess the effectiveness and consistency of the application of	The Health Board will complete a baseline using the ward-based audit tool, Tendable, prior to adoption of	June 2025	Head of Integrated Discharge

Ref	Recommendation	Organisational response	Completion date	Responsible officer
	the discharge policy and associated training programmes.	the new policy and then review monthly to assess impact.		
R4	The Health Board should improve record keeping by: 4.1 ensuring all staff involved in discharge planning fully understand the importance of documenting comprehensive information in-patient case-notes to support effective discharge planning. 4.2 establishing a programme of case-note audits focused on the quality of record keeping.	i. This is being incorporated into the rolling programme of education for ward teams. In addition, there is a pilot underway in which a discharge booklet is being trialled on the winter ward in UHL to support clear documentation of discharge processes in patient case notes. ii. The Health Board will assess the best tools and process for auditing record keeping and, if appropriate, roll this out with ongoing training and audit cycles.	June 2025	Head of Integrated Discharge
R5	The Health Board, in partnership with its local authorities, should ensure it has the necessary arrangements in place to embed and deliver a seven-day working week approach to hospital discharge to minimise unnecessary stays in hospital.	Consultant seven-day working in the acute footprint is now in place to support weekend discharge. In addition, there is a seven-day working group set up to embed the improvements and look to develop this further as part of the ministerial initiative 50-day winter challenge.	Already in place	Chief Operating Officer

Ref	Recommendation	Organisational response	Completion date	Responsible officer
R6	The region should ensure its action plan for pathways of care is clearer on the intended outcomes from the actions it has identified. It should also undertake regular review to assess whether outcomes are being achieved.	i. A detailed POCD action plan is in place. ii. POCD action plan is reviewed monthly through a local partnership forum and is reviewed quarterly by the Welsh Government in line with the Care Action Committee Cabinet Secretary priorities. iii. The Care Action Committee reviews the impact and outcomes achieved by the plan on a monthly basis as one if its three national priorities. iv. The national Six Goals for Urgent and Emergency Care team undertakes a detailed review of POCD data with the local team and supports identification of priorities for action locally. We will continue with these governance arrangements and monitor the impact on an ongoing basis.	Already in place.	Head of Integrated Discharge

Ref	Recommendation	Organisational response	Completion date	Responsible officer
		v. The impact of the action plan and associated data are regularly reviewed through partnership governance arrangements.		
R7	To help inform decision-making and discussions, the Health Board and local authorities should ensure that the Regional Partnership Board has routine access to key performance indicators relevant to effective and timely flow out of hospital, including urgent and emergency care performance within the Health Board and waiting lists for social services and care packages.	i. POCD data is currently regularly shared with the RPB Strategic Leadership Group through both specific programme reporting and CAC priority briefings. ii. The RPB team will review the key performance indicators already collected and ensure they are shared in the appropriate forums.	April 2025	Director of Health and Social Care Integration

Exhibit source: Cardiff and Vale Regional Partnership Board partners.

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ADSS Cymru
Yn arwain Gwasanaethau Cymdeithasol yng Nghymru
Leading Social Services in Wales

Senedd Cymru Local Government and Housing Committee: Inquiry into the role of Local Authorities in supporting hospital discharges

Contribution by ADSS Cymru

Authority	Lance Carver – Cadeirydd, ADSS Cymru Jason Bennett – Chair, All Wales Adult Services Heads (AWASH)
Completed by	Paul Pavia, Policy and Research Lead
Date	February 2025

General Comment

The Association of Directors of Social Services (ADSS) Cymru is the professional and strategic leadership organisation for social services in Wales and is composed of statutory directors of social services, the All-Wales Heads of Children's Service (AWHOCs), the All-Wales Adult Service Heads (AWASH) and tier three managers who support them in delivering statutory responsibilities: a group which consists of over 300 social services leaders across the 22 local authorities in Wales.

The role of ADSS Cymru is to represent the collective, authoritative voice of senior social care leaders who support vulnerable adults and children, their families, and communities, on a range of national and regional issues in relation to social care policy, practice, and resourcing. It is the only national body that articulates the view of those professionals who lead our social care services.

As a member-led organisation, ADSS Cymru is committed to using the wealth of its members' experience and expertise. We work in partnership with a wide range of partners and stakeholders to influence the important strategic decisions around the development of health, social care, and public service delivery. Ultimately, our aim is to benefit the people our services support and the people who work within those services.

Foreword

ADSS Cymru welcomes the opportunity to contribute to this Senedd inquiry. We also gave extensive evidence to the Health and Social Care Committee's inquiry into Hospital discharge and its impact on patient flow through hospitals, which reported in the summer of 2022.[1]

However, we believe that the terms of reference for this inquiry reflect an overly narrow perspective on the issue, one that prioritises hospital processes over the fundamental goal of enabling individuals to live well within their communities. Put simply we believe that there should be a greater emphasis on patient outcomes rather than patient flow.

The inquiry's framework positions local authorities - primarily social services - as responsible for ensuring hospital efficiency rather than as partners in a broader system designed to support people in living independently. This approach does not fully recognise the statutory role of local authorities, as set out in the Social Services and Wellbeing (Wales) Act 2014, which is to promote the wellbeing of individuals and ensure they receive the right care and support within the most

[1] ADSS Cymru/WLGA, *Senedd Cymru Health and Social Care Committee: Inquiry into hospital discharge and its impact on patient flow through hospital*, 2022.

appropriate setting. The term “hospital discharge” itself is not recognised in this legislative framework. Instead, social services are tasked with supporting people to live safely at home, reducing the need for hospital admission and ensuring timely, well-planned transitions back into the community.

We think it would be of greater benefit to examine the effectiveness of hospitals, community health services, and local authorities in working together to support individuals to remain at home, return home, and avoid unnecessary hospital admissions. The focus should not solely be on the logistics of hospital discharge, but on the extent to which the entire health and social care system is structured to deliver outcomes that align with the needs and aspirations of individuals and communities.

Moreover, the challenges identified in the inquiry’s terms of reference must be considered in the context of systemic factors that shape the ability of local authorities to provide support. Workforce shortages, delays in assessments, and difficulties in arranging care provision are not just obstacles to discharge but are reflective of broader pressures within the social care sector. These pressures are exacerbated by a lack of parity in terms and conditions between the social care and health workforce, inconsistencies in community investment, and the continued challenge of ensuring integrated, person-centred care. Investment in community-based services and early intervention is key to reducing unnecessary hospital admissions and facilitating sustainable care pathways. Social Services departments spend increasing sums supporting more and more people to live in their communities.

In submitting this evidence, ADSS Cymru respectfully suggests the Committee reconsider the framing of this inquiry, ensuring that the debate centres on how the whole system - NHS, local authorities, and community partners - can collaborate using strengths-based approaches to uphold the principles of person-centred care and independent living. We believe this would help to move beyond short-term fixes towards a genuinely integrated approach that serves the best interests of individuals, families, and communities across Wales.

Introduction

Delays in hospital discharge and timely transfer of care to other secondary providers, primary care and community care, have a significant impact on people in receipt of care their families and carers. It also impacts on citizens requiring admission into hospital, so therefore, discharge and transfer of care planning and its effective implementation is everyone’s business. Multi-Disciplinary Teams (MDT) at both ends of the system, are critical to its successful delivery.

Over the past decades, there has been a great deal of work to both understand the issues and causes of delayed pathways of care and poor patient flows, along with tools and resources to address these. We should consider a delayed pathway as of a symptom of wider challenges in the integrated health and social care support for our citizens.

The varying complexity of delayed pathways require effective partnership working by health and social care organisations, as well as third sector and independent providers. Moreover, in line with the Social Services and Well-being (Wales) Act 2014 and the Principles of Prudent Healthcare, joint working should be driven by the voice of individuals and carers and what matters to them, not just professionals. It is pivotal that the principles of co-production are at the centre of arranging and providing care because supporting people to safely transfer from one setting to the next needs

a person-centred, whole systems approach, with agreed joint protocols and practices to achieve the best outcomes.

Therefore, a delayed discharge can be an indication of both service pressures and/or ineffective collaboration in terms of planning, commissioning, and delivery, contributing to systemic failure. The situation is further complicated by the design of services that position the hospital as the ultimate fallback care option, resulting in a tendency for everything to gravitate towards the hospital. This strategy not only depletes community resources but also intensifies the difficulties encountered by both social care and the NHS.

Given that this is such a complex issue, we strongly believe that in pursuing a whole systems approach in the planning, commissioning and delivery of health and care services, to fixate on this one area in isolation would be to miss the point. Fundamentally, we need to ensure we are shifting our focus from secondary hospital-based care to supporting independence, wellbeing and preventative care in the community as articulated in *A Healthier Wales,* as well as the local government's *'Vision for Social Care'.*[2]

This submission will consider a number of issues surrounding the misconceptions that social services delayed discharges are the major contributing factor when considering the lack of available hospital beds in Wales. There is no doubt that social care has a role in supporting people to return home when well enough to do so, but rhetoric that attributes all the issues to this one singular area are inaccurate and unhelpful.

We will explore:

- What is meant by the term 'delay'?
- How integration has led to a shift of responsibilities
- The whole system context - community activity v hospital discharge
- Demographic changes and increased demand
- Increasing complexity of care needs
- The significant reduction in hospital beds (including mental health and dementia) over last the 15 years
- Avoidable harm and deconditioning in hospitals
- The unfunded costs to local authorities in supporting early discharge / avoiding admissions
- Unacceptable gatekeeping of NHS Continuing Healthcare (CHC)
- Why recording a 'delay' after just 48hrs is unreasonable

What's meant by the term "delay"?

Before the COVID-19 pandemic, the measurement was delayed transfers of care, (DToC) a delay at that point was any person in hospital more than 24 hours after their estimated date of discharge, (EDD). The EDD was an agreed date set by all the professionals on an individualised basis as the likely date the person would have everything in place to be able to go home. This was open to interpretation and therefore lacked some national consistency.

The current system of monitoring "pathways of care" may use some coding and language that is similar to the former DToC but is fundamentally different. Old phraseology like EDD and "medically fit" have been replaced with a new definition of "clinically optimised", which describes a state

[2] ADSS Cymru et. al., *A Vision for Social Care*, 2022.

where a person no longer needs the acute medical intervention that a hospital provides and can continue their treatment, recovery and convalescence elsewhere. The monitoring of the pathway of care is intended to assist with process mapping, identification of system wide pressure points, and to consider if the right resources are in place in each of the pathways.

This pathway monitoring has also become a new way of national reporting and people are now reported as a "pathway of care delay" (PoCD) if they have not moved out of hospital within 48hrs of this clinical determination. In many circumstances, the PoCD will be significantly earlier in the person's recovery than the previous EDD & DToC consideration. It will also, by its very nature, include individuals who are still very unwell / not fully recovered from whatever event led to their need for hospital care.

Support for a person who is unwell or requires rehabilitation is a core function of the NHS. The current system of monitoring pathway delays, expectation of "early supported discharge" for a person still suffering the impact of their illness, "discharge to recover & assess" known as 'D2RA', creates an expectation that social care will assume responsibility for individuals who would have previously had NHS care for their treatment and recovery.[3]

However, it should be noted that the primary legislation in Wales has not changed, neither has the core funding allocation to local government to allow for this increased cost. (See cost calculator section).

Primary Legislation

NHS (Wales) Act 2006

Part 1 Promotion and provision of the health service in Wales

(1) The Welsh Ministers must continue the promotion in Wales of a comprehensive health service, designed to secure improvement

a) In the physical and mental health of the people of Wales; and

b) the prevention, diagnosis and treatment of illness*

(2) The Welsh Ministers must for that purpose provide or secure the provision of services in accordance with this Act.

(3) (e) Such other services or facilities for the prevention of illness*, the care of persons suffering from illness and **the aftercare of persons** who have suffered from illness as they consider are appropriate as part of a health service,

(f) Such other services or facilities as are required for the diagnosis and treatment of illness.* [4]

Social Services and Wellbeing (Wales) Act 2014

Section 19 Duty to Assess the needs of people who may need care and support

Section 32 Determination of eligibility (set nationally)

[3] NHS Wales Executive, *Six Goals for Urgent and Emergency National Care Programme – Goal 6* (2022).
[4] The term "illness" is defined in Section 206 of the NHS (Wales) Act 2006 and includes any 'disorder or disability of the mind and any injury or disability requiring medical treatment or nursing'.

Section 34 Duty to meet eligible needs except for those in Section 47

Section 47 Exception for provision of health services

(1) A local authority may not meet a person's needs for care and support (including a carer's needs for support) under sections 35 to 45 by providing or arranging for the provision of a service or facility which is required to be provided under a health enactment, unless doing so would be incidental or ancillary to securing another service or facility for that person under that section.

(2) A local authority may not secure services or facilities for a person under section 15 (Preventative Services)* that are required to be provided under a health enactment, unless doing so would be incidental or ancillary to securing another service or facility for that person under that section. [5]

How integration has led to a shift of responsibilities

As we can see in the previous section, the legislation is very clear in terms of responsibilities for both the NHS and social care. However, we recognise that services which are integrated offer much better outcomes for our residents, and integration is promoted by Welsh Government policy. It makes sense to provide coordinated community services for our citizens.

Nevertheless, the reality of integration in Wales is that in many ways it has become a rationale to shift responsibility from the NHS to social care. Local Authorities are arranging support for people with NHS needs, and care workers are doing more health-related tasks than ever before. This gradual drift of responsibility has come without a change of legislation, meaning that local authorities are often going beyond their statutory duties, as outlined in Section 47 above.

Furthermore, there has been no corresponding change in core funding formulas for local government or NHS services. There has also not been a change of grade for care workers who are often employed on terms and conditions that are significantly below the NHS pay and grading structure, which would evaluate similar roles with similar responsibilities at a much higher level of renumeration.

This shift in responsibility has increased costs for local government, as detailed in our recent submission to the Senedd's Finance Committee during the scrutiny of the Welsh Government's Draft Budget for 2025-26.[6]

Whole system context – community activity vs hospital discharge

As we prefaced both in the foreword and introduction, whilst delays associated with the hospital are important, they should be seen in a whole system context. The number of people in a hospital

[5] Under Part 2, Section 15 (Preventive Services) of the Act, there is a very detailed definition of preventative services where it pertains to adults. A local authority must provide or arrange for the provision of a range and level of services which it considers will achieve the purposes in subsection (2) in its area. (2) These purposes are - (a) contributing towards preventing or delaying the development of people's needs for care and support; (b) reducing the needs for care and support of people who have such needs; (d) minimising the effect on disabled people of their disabilities; (e) contributing towards preventing people from suffering abuse or neglect; (i) enabling people to live their lives as independently as possible.

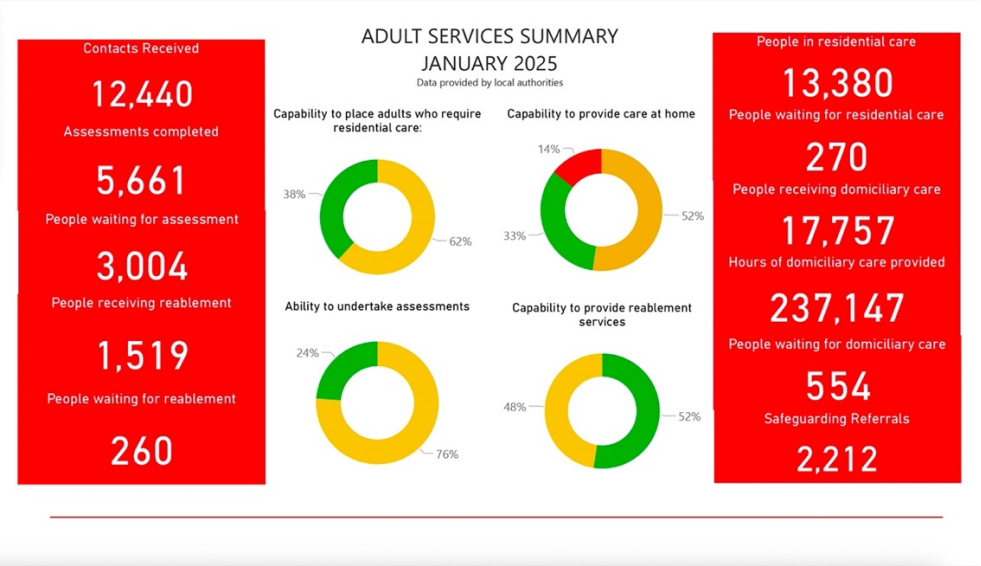
[6] ADSS Cymru/WLGA, *Senedd Cymru Finance Committee: Welsh Government Draft Budget 2025-26* (December 2024).

bed who need social care intervention is a very small proportion of the work of social care. To put this in context, adult social care teams in Wales complete over 70,000 assessments each year.

- **2021-22** - 70,884 assessments[7] with 50,640 care & support plans
- **2022-23** - 74,417 assessments completed with 50,144 care and support plans.[8]

For the purpose of comparison, the following data represents a one-month snapshot obtained from social services checkpoint data. This information, collected by local authorities, is compiled by the Welsh Government to develop a performance monitoring dashboard.

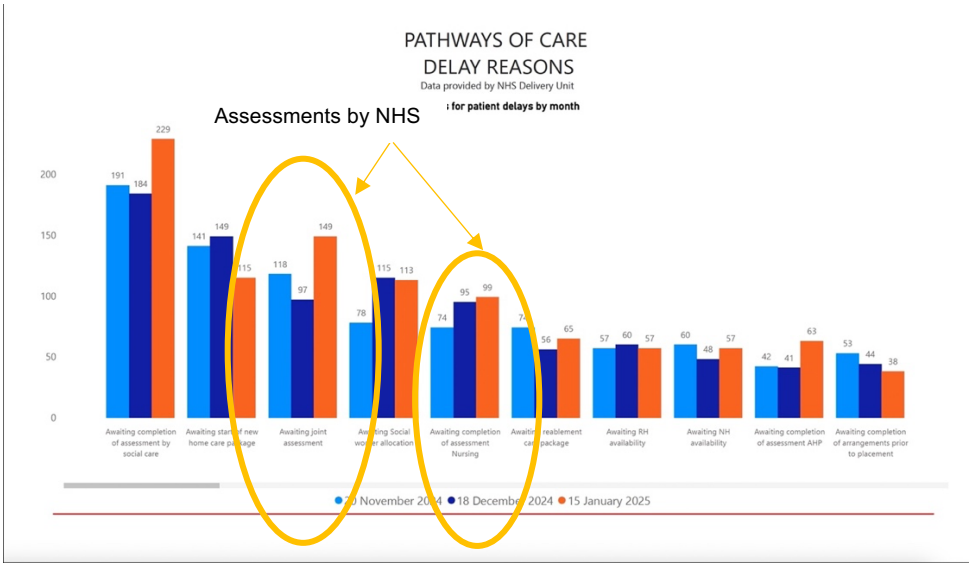
January 2025 Snap-shot



In January 2025, of the 5,661 completed assessments, only 229 individuals were clinically optimised hospital patients and working with social care to finalise their discharge plans. There were also 113 new hospital referrals awaiting social work allocation.[9]

These figures go some way to demonstrating the number of people supported by social services teams every day, with well over 1,000 people making contact with social services daily. Of the 370 new assessments undertaken every day, over 4 in 5 of these (82%) lead to that individual's needs needing to be met, either through a care and support plan or by other means. Compared with the previous year there has been a 13% increase in the number of contacts made to social service and a 7% increase in the number of new assessments undertaken. By way of example, one council has reported that they have experienced a 15% increase in demand across all client groups in Adult Services in the last year.

[7] StatsWales, New assessments completed during the year, by local authority (April, 2024).
[8] StatsWales, Adults with a care and support plan at 31 March, by local authority (April, 2024).
[9] StatsWales, Pathway of care delays by reason for delay and date (February, 2025).



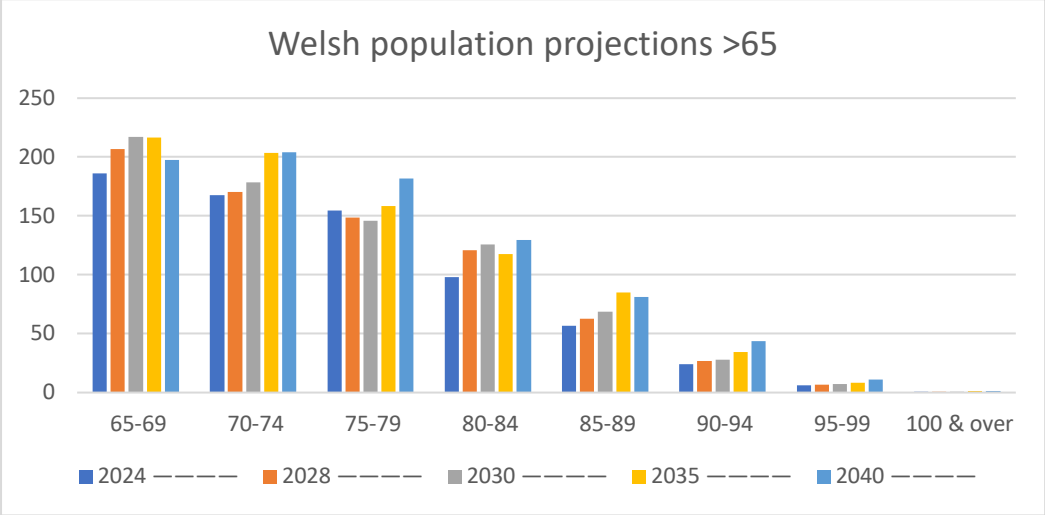
There is often a narrative about assessment delays being "*social care delays*". However, it is important to acknowledge that there are a range of other factors that extend beyond social care. Such delays can also result from issues like patients waiting for nursing assessments, Continuing Health Care (CHC) assessments, delays in completion of medical and psychiatric assessments and the time taken for medicines management arrangements to be finalised. As we can see from the graph above, delays related to assessment for "joint" and "nursing" when combined are higher than those waiting for "*social care*". It should also be noted that a social worker cannot fully complete their assessment until they have consulted with relevant professionals, families and, most importantly, the individual and any advocates they may have supporting them.

So "awaiting completion of social care assessment" should really be considered as "social worker is actively working with the person, the MDT and family". An assessment is not a "tick box" quick conversation. Rather, it is a detailed, skilled professional interaction with the individual and other relevant parties to formulate and agreed plan of care and support for those people with eligible needs. Social workers are highly skilled, trained professionals and whilst initiatives like "trusted assessor" can support non-complex arrangements, there will always be a cohort of people who need this specialist intervention. We have provided an insight from a social worker in Annex 2, which sets this out in more detail.

Demographic changes and increased demand

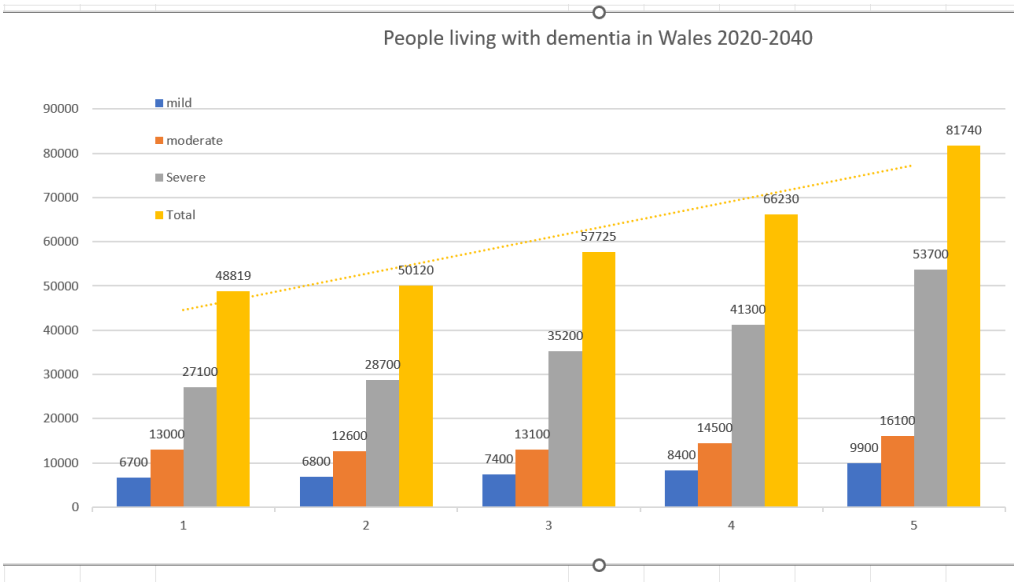
Demographic data indicates an increasing older population in Wales, which is positive for the majority of our population. The Office of National Statistics data shows that mid-2022 there were 1.7 million people aged 85 years and over, making up 2.5% of the population. By mid-2047, this is projected to have nearly doubled to 3.3 million, representing 4.3% of the total UK population. There are projected to be many more people at older ages by 2047, in part because of larger cohorts from the 1960s now being aged over 80 years, as well as general increases in life expectancy.[10]

[10] Office of National Statistics, National Population Projections: 2022-based (January 2025).



However, this increase will also bring challenges, with a higher likelihood of individuals requiring health and social care services. Clinical advancements have improved survival but has led to a more complex range of needs and comorbidities within the population, and this is expected to grow. This shift will lead to a rise in the overall amount of ill-health, with more cases of chronic conditions, multi-morbidities, and cognitive impairments – increased risk factors which impact an individual's ability to return home. As a result, the increasing prevalence of long-term frailty is anticipated to significantly elevate the demand for social care services.

Associated with the aging population we see an increase in the number of people who have a form of dementia.



Alzheimer's Society UK (2019)

This cognitive impairment can at later stages lead to many complexities in terms of care and support which will impact on hospital discharge arrangements for some people. This is particulary significant for people who are no longer able to direct their own needs, make decisions about their care or have the ability to return home. The pathways of care monitoring data shows an increasing number of people who need mental capacity assessments, best interest decisions and involvement of the Court of Protection to arrange their ongoing care.

Despite the demographic challenges we can show a year-on-year improvement in terms of hospital flow against a backdrop of increasing demand, a huge reduction in hospital beds and concerns with inpatient care. Poor discharges and readmissions are increasingly commonplace as an under-pressure system attempts to balance risk of early discharge with attendances at emergency departments.

This is one case example of poor discharge planning captured by a local authority in Wales, where a frail elderly woman was discharged late from hospital on Christmas Eve 2024:

"*No-one knew she was being discharged, she was doubly incontinent and wasn't even wearing her own clothes when her son found her at home, by chance. She ended up going straight back to the hospital that evening! It was escalated to local NHS, yet no response or action was taken to investigate what happened.*"

Increasing complexity of care needs

With the changes in demographics and advancement in health care people are living longer with more complex medical conditions. Increased physical frailty and age-related cognitive decline such as dementia combine for many people. This can present a challenge for the individual, their family & unpaid carers and for assessment and care planning. The social work assessment has to gather information about both physical, cognitive and psychological impact of the persons presentation, their views wishes and feelings. Care planning is increasingly complex with the interface between health and social care needs needing a combined, integrated approach.

We have observed in Care Action Committee and pathways of care data that more people require joint health and social care assessments to support them to be discharged from hospital. We are also seeing a steady increase in the number of people who require Mental Capacity Act assessments, Best Interests decisions and the involvement of the Court or Protection to agree their care arrangements for discharge. These are intensive processes with a clear legal framework and by very nature take considerable time. Anyone with such needs is inevitably going to be in hospital more than 48hrs after being deemed 'clinically optimised'.

In April 2023, there were 32 delays associated with mental capacity & court of protection. In January 2025, this figure had more than doubled and has risen to 73.

Pathway of Care Delays by reason for delay and date

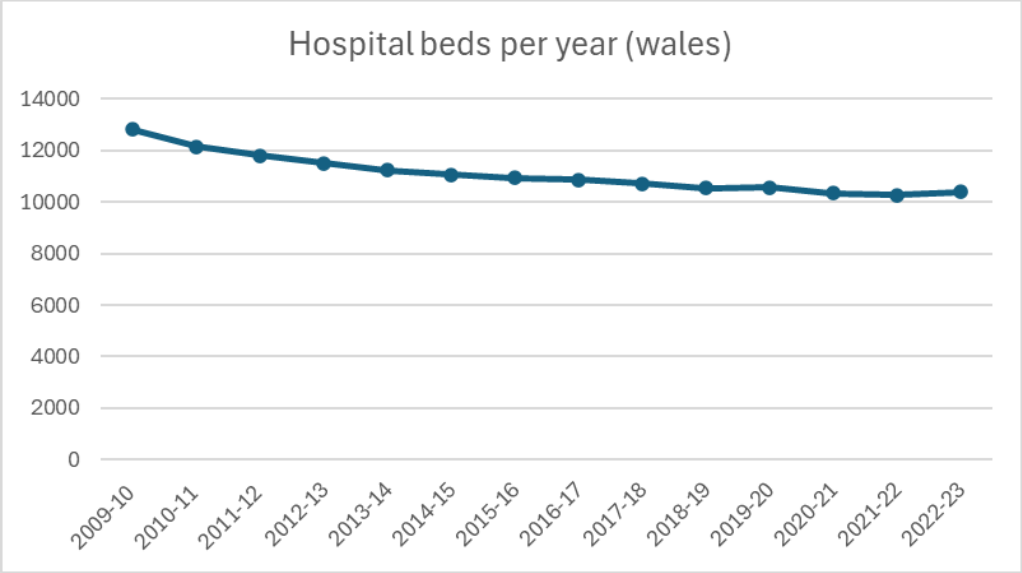
The significant reduction in hospital beds (including mental health and dementia) over last the 15 years

Despite increasing demographic demand and complexity we have seen a significant reduction in the number of hospital beds (including mental health and dementia) in Wales, with approximately 19% lost.

Year	Number of Hospital Beds[11]
2009-10	12,807
2010-11	12,149 ↓5.1%
2011-12	11,810 ↓2.8%

[11] StatsWales, NHS beds summary by year, 1989-90 onwards (August 2024).

2012-13	11,497 ↓2.7%
2013-14	11,241 ↓2.2%
2014-15	11,062 ↓1.6%
2015-16	10,935 ↓1.2%
2016-17	10,857 ↓0.7%
2017-18	10,712 ↓1.3%
2018-19	10,549 ↓1.5%
2019-20	10,564 ↓0.1%
2020-21	10,340 ↓2.1%
2021-22	10,276 ↓0.6%
2022-23	10,400 ↑1.2%
2023-24	10,446 ↑0.4%



Actual performance in relation to pathway of care

We often hear that the problems being faced by our acute hospital system directly correlate to social care delays, whilst this will have some impact, the preoccupation in this area may be disproportionate as the data below shows these “delays” in context of all available beds. At the end of January 2025, the total number of people recorded as their pathway being “delayed” (1,502 for all reasons) remains well below the reduction in the number of beds since 2009 (2,361 beds).

	Jan-25		
All Wales Data	**Jan-25**	**as % of all delays**	**as % of all beds**
Total Delays (All reasons)	**1502**		
Awaiting completion of assessment by social care	229	15.3	2.19
Awaiting completion of assessment by health	223	14.9	2.13
Awaiting start of new home care package	116	7.7	1.11
Awaiting social worker allocation	113	7.5	1.08
Awaiting joint assessment	150	10.0	1.44
Awaiting placement arrangements	38	2.5	0.36
Awaiting Residential Home availability	57	3.8	0.55
Awaiting Nursing Home Availability	57	3.8	0.55
Awaiting reablement care package	65	4.3	0.62
Awaiting funding decision FNC/CHC	24	1.6	0.23
Increasing complexity	**Jan-25**		
Mental Capacity / Court of Protection delays	65	4.3	0.62
Patient, family choice & refusal to move/be discharged	50	3.3	0.48

Avoidable harm and deconditioning in hospitals

Therapy staff in our hospitals are frequently required to assist with discharge planning due to a decrease in inpatient recovery and rehabilitation services, under the assumption that such care will be provided within the community once the patient has returned home. This shift of emphasis may indeed be better for the person but also represents a shift in responsibility from the NHS to social services & reablement teams, as previously referenced above.

In this regard, it should be noted that investment in community health services has not kept pace with demand or with the closure of beds.

The NHS Wales Executive 6 Goals for Urgent and Emergency National Programme, has one goal (Goal 5: Optimal hospital care and discharge practice from the point of admission) that is centred on inpatient care, to "*prevent deconditioning*". This programme seeks to redress an issue where suboptimal inpatient care and a lack of rehabilitation / therapy intervention, is leading to people coming to harm in our hospitals. It is important to highlight that inpatient therapy services are extremely limited or not available on weekends or bank holidays, which leads to increased levels of deconditioning and places additional strain on community services.

It is concerning to note that *"10 days in hospital (acute or community) leads to the equivalent of 10 years ageing in the muscles of people over 80 years old."*[12] This highlights the importance of delivering optimal outcomes and experiences for individuals in hospital settings.

This avoidable harm and loss of independence means older / frail people are more likely to require some form of care and support to return home, increasing the pressures on social care and already stretched community services. Rather than address the root cause of deconditioning i.e. suboptimal care, we see this being used as a rationale to move people out of hospital earlier.

We fear suboptimal hospital care is not only being unreported but has also become accepted. This rhetoric must be challenged, as routinely failing patients in our hospitals is unacceptable.

It is important to note that if a registered care provider, such as a residential care home, were found to be routinely "deconditioning an individual," it would be considered neglect. Such cases would be referred to the regulator, Care Inspectorate Wales, and assessed under safeguarding procedures. Without improvement, the care provider could face deregistration.

Social care has a responsibility to meet care and support needs as outlined in the Social Services and Wellbeing (Wales) Act 2014 national eligibility criteria. It should be noted this eligibility does not cover short-term illness or recovery from illness, which are features of the NHS Wales Act 2006. Although it does provide for the provision of reablement services, which the Act states should be jointly delivered with the NHS. This provision does not stipulate the type and nature of such services or the contributions from each partner, as a result, investment varies greatly across Wales, with the NHS contributing much less in some areas than others.

[12] NHS Wales Executive, *Delivering optimal outcomes and experience for people in hospital*, 2022.

The unfunded costs to local authorities in supporting early discharge / avoiding admissions

We have seen a number of initiatives to reduce the time spent in hospital, whether this was 1,000 beds[13] or the current 50-day challenge[14] and the ask is a similar one; for local authorities to support people to move out of hospital as quickly as possible and to provide this care in the community. This shift of care and responsibility, whilst attracting some short-term grant funding, comes at a significant cost to local authorities, affecting their ability to deliver wider community-based support.

While councils have made progress in reducing delays and expanding domiciliary and reablement services this has often come at the expense of other key areas of social care. With resources and staffing redirected to prioritising hospital discharges, services such as preventative care, early intervention, and long-term support for vulnerable individuals have faced increasing strain.

For example, to support a reduction in the length of a hospital stay by just 2 days for just one person (every day) who requires home care each day will cost the local authority circa £1,100 per week. Similarly, moving just one person a day to a care home to reduce the length of stay by 5 days, would cost £6,000 per week.

Similar work to provide care to prevent hospital admission also results in costs to local authorities. Preventing a 10-day admission (average for all ambulatory sensitive conditions) by providing domiciliary care for one person a day would cost approx. £5,100 or would cost £12,000 if one person a day was supported in residential care, instead of hospital for the same 10 days.

If we combine the relatively modest numbers above, the additional cost to this local authority in these scenarios is £1.23M per annum. If this was not provided, the cost to the NHS for this care in a hospital at £450 per person per day would be circa £4.4M per annum.

Whilst social care is more cost effective in this scenario, the hospital pressures mean that the £4.4M is not a cashable saving and the corresponding £1.23M investment in social care has not been forthcoming.

If we scale this further for all Wales i.e. all 22 local authorities, for just this minimal intervention we would see a cost of approximately £28M to local authorities and a corresponding cost avoidance to the NHS of £97M.

This demonstrates that a balanced approach is important; while hospital discharge is necessary, social care must also have the capacity to provide preventative and ongoing support. Without this balance, pressures on hospitals may reduce in the short term, but the demand for crisis interventions could increase, potentially making the system less sustainable over time.

[13] A Care Action Committee (CAC) was established in 2022 and chaired by the then Minister for Health and Social Care. It included key members from local government, health, and social care sectors. The CAC aimed to provide an additional 1,000 beds or equivalent community services during the 2022/23 winter period to ease system pressure and reduce delayed discharges. Although the target was not fully achieved, over 670 beds or equivalents were provided, significantly improving flow across the health and social care system.

[14] Welsh Government, *New 50-day challenge to improve hospital discharge and community care*,

Unacceptable gatekeeping of NHS Continuing Healthcare (CHC)

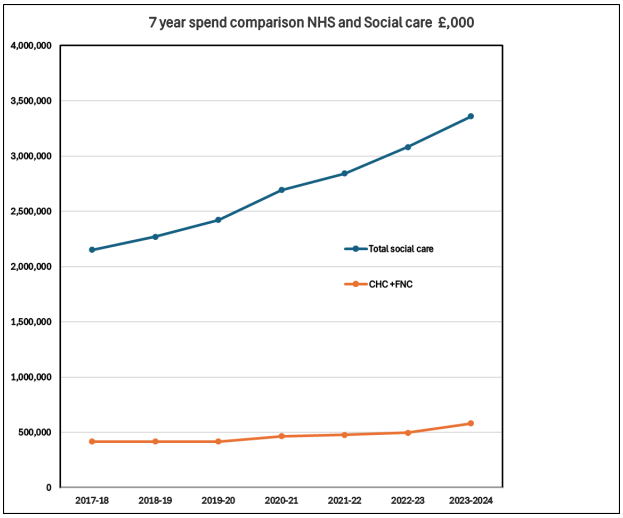
Despite demographic increases and increasing complexity, NHS Continuing Healthcare (CHC) budgets are not increasing to match this demand and in real terms are often reducing. Eligible citizens have a legal right to their entitlement for NHS care. Further, it can increase clinical risks as the wrong professionals are overseeing what should be clinically led care. We previously highlighted this in both the Senedd's Health and Social Care Committee's inquiry into supporting people with chronic conditions[15] and, most recently, in its scrutiny of the Health and Social Care (Wales) Bill.[16]

Delays in NHS agreement of funding of care arrangements for discharge from hospital in January 2025 was 24, (Stats Wales) this delay often relates to a panel decision regarding authorisation. It should be noted that all local authorities in Wales have confirmed that none of them use a panel for hospital discharge and have a clear scheme of delegation to enable rapid decision making.

By failing to apply CHC as outlined in the national policy, the NHS are, by default, utilising social care resources and staff that should be deployed to fill social care activities and are continually increasing local authority costs. Care workers being paid at, or around real living wage levels, are undertaking more and more complex, health-related activities. Yet, their status and renumeration is significantly below that of NHS directly employed staff and reduces the market capacity for social care. If the NHS were to directly deliver CHC care, we would see significant capacity released to the social care sector which would in turn increase responsiveness of the sector.

The inability to transfer care coordination has clinical risks and increases the risk of harm. Across Wales we see what might considered unlawful practice by the NHS in order to protect their budget and resources, with social care stepping in or continuing to provide care to people with clear health needs. There are many instances where local authorities are considering court intervention, including judicial review, in order to remedy this matter. Local authorities are routinely being forced to work outside their legal remit in order to ensure families have support.

Furthermore, the differential growth in spend between social care and NHS on funded nursing care and continuing care is shown in the graph below. This does not seem to correlate with the narrative of shift of investment from closure of hospital beds to a position of supporting people in their communities.



[15] ADSS Cymru, *Senedd Cymru Health and Social Care Committee: Supporting people with chronic conditions*, (2023).
[16] ADSS Cymru, *Senedd Cymru Health and Social Care Committee: Health and Social Care (Wales) Bill*, (June, 2024).

Moreover, analysis we have undertaken reveals stark inconsistencies in CHC and FNC funding across different health boards, leading to disparities in care access and creating inequities in service provision. It is also the case that CHC eligibility criteria seemed to vary across Wales, affecting equitable access to funding. Individuals in some health board regions were twice as likely to receive CHC funding compared to others, highlighting an inequitable system. Some local authorities were experiencing significant delays in CHC decisions, prolonging hospital stays unnecessarily. All of this places additional strain on local authority budgets because councils end up providing the care whilst negotiations on who pays for the care drag on for months, sometimes years.

Delays were noted by the NHS Executive in relation to hospital discharge for people with healthcare needs, and in Care Action Committee. Rather than address the root cause of these delays, such as bureaucratic processes around CHC and monitoring NHS performance the 50-day challenge suggested a policy of “no CHC consideration for hospital discharge”. As outlined above, section 47 of the Social Services and Wellbeing (Wales) Act would prohibit social services from providing this care, yet some NHS bodies have interpreted the 50-day challenge to suggest that social care will provide such support pending consideration.

The CHC framework has an 8-week timescale for routine consideration and a fast process for people with more critical needs including end of life care. These timescales are systematically not adhered to and are not nationally monitored yet we monitor every stage of social care process for discharge. This is clearly an inequity that needs to change.

Why recording a ‘delay’ after just 48hrs is unreasonable

The new monitoring of pathways of care has a trigger point of a patient becoming “clinically optimised”. As previously stated this does not necessarily mean the person is well or recovered. This clinically optimised determination starts the virtual clock and anyone still in hospital 48hrs later is considered a “delay”. For many people with less complex needs, discharge will be via agreed pathways such as reablement.

For people with more complex needs they may require a range of services to support them to be discharged from hospital as they continue to recover. In order to determine the correct services a level of assessment is needed with the person, their family and the MDT. A care & support plan must be mutually agreed and the relevant care commissioned and arranged.

Meeting a new person such as social worker, trying to agree a plan for your care needs, discussing things with your family at visiting time, having views from the MDT on your care is a complex and difficult time for people, and can be overwhelming. Doing this whilst you are still unwell / not recovered from an acute illness is considerably more difficult.

Imagine a travel agent calling you whilst you had a cold / flu and asking you to try to plan a family holiday, it is very unlikely you would make a decision immediately, and would want time to consider your options, consult with your family, check your finances etc. Yet we expect people to work through an assessment, agree a care plan sometimes including moving to a care home which may cost the person up to £2,000 a week and for this to all be in place within 48hrs, or we will record this as a “delay” and will consider “reluctant discharge” policies being used.

Care must be taken to remember the individual at the centre of pathways of care discussions and their individual circumstances when planning discharge and ensuring this is done in a safe and timely manner. We acknowledge there must be a determining point in the persons journey home for monitoring purposes, but considering transfer home for a person with complex needs as being

“delayed” if this takes more than 48hrs from them becoming ‘clinically optimised’ is clearly not a person-centred approach. (Please see Appendix 1 - care home process).

Conclusion

In conclusion, addressing the current challenges in our hospital settings requires a whole system approach that emphasises a collaboration between the NHS, local authorities, and community partners, rather than looking at one piece of the puzzle in isolation.

By focusing on person-centred care and fully integrated support systems, we can ensure that individuals receive the right care at the right time in the right setting. It is essential to invest in local authorities, community-based services and timely interventions that reduce unnecessary hospital admissions and facilitate sustainable care pathways. By re-evaluating the framework of this inquiry, we can move towards a genuinely integrated approach that serves the best interests of individuals, families, and communities across Wales.

Appendix 1: High level steps require to support a person to move to a care home

Referral – any source

Screening / Triage / Information, Assistance, Advice

How complex is this situation. Trusted assessor. Can care needs be met in the community. Likely to be self funding, person's known wishes and feelings, view of unpaid carers, indication of mental capacity needing to be considered, is the person well enough to start the assessment process etc

Allocation to a social worker as situation is complex

Initial considerations, capacity and consent to assessment / able to make decisions, background history, likelihood of needing MDT assessments to inform the Integrated Assessment e.g. Doctor, Occupational Therapist, nursing needs assessment etc. Persons wishes and feelings, family wishes and feelings.

Can the person go **home**? If not why not?

Integrated assessment under the Social Services and Wellbeing (Wales) Act 2014

For people with complex needs this is a skilled social work process, not just filling in a form, it must focus on the person's wishes and feelings ("what matters"), consider family wishes and feelings. Assess eligibility and look at persons personal outcomes care and support needs, this should include any Multidisciplinary team (MDT) assessments and recommendations, may need to include consideration of Mental Capacity Act, deprivations of liberty and MDT "best interest" decisions.

Can person be supported at **home**? If not why not?

Residential care is different from Nursing Care (latter must have nursing assessment completed and under the framework CHC must be considered prior to agreeing funded nursing care)

Care plan agreed with person / family outlining personal outcomes to be met.

Choice Family / person supported to choose a care home

Financial Assessment explained and completed. Self-funding? top up fee? affordability? Consideration for future sale of property / assets, impact on other family members at property etc. Inheritance. Deferred payment agreements/ legal charges etc. Some care home fees are approaching £2,000 per week, if you were spending £100K per year of your own money what level of choice and control would you expect to have about where you live and who with?

Preferred care provider is given the assessments & care plan to consider if they can meet the person's needs (RISCA requirement).

We may need the **Court of Protection** to authorise the move to the care home for some people.

Transport arranged to the care home for the person and some of their personal effects.

Personal belongings, for many people the space for personal items will be much reduced from a lifetime of living at home and can create a sense of loss – Which items would you take / leave if you were moving home? You would probably have a moving lorry. Now think that someone tells you that you can only have what will fit into a family car how would you feel?

A different life Person moves to a care home, they and their family adjust to a very different life.

For a person in hospital, <u>ALL THIS</u> should happen within 48 HRs of being clinically optimised otherwise we record it as a delay!

Annex 2 – Why do we need qualified social workers in hospital settings?

A personal insight from Alison Johnson – Social Worker and Team Manager for RCT Hospital Discharge Service.

With the growing introduction of Trusted Assessors in hospitals, it is certainly prudent to ask this question. All health and social care services currently exist in a context of a continued drive for efficiencies and savings - in not just time, but also in resources to meet ever growing demand. Providing advice, information and support as well as assessments of need by a generalist practitioner certainly has its place within the system of hospital discharge and can add immense value to the preventative agenda by linking people in with services and support at an earlier stage in their care journey. Additionally, freeing up more specialist practitioners from non-complex work provides a much-needed ease to demand volume on social work teams.

However, it is also vital to recognise the circumstances in which only input from a qualified practitioner will meet the needs and objectives of the individual, whether that be social work, occupational therapy or any of the allied professionals that form part of the multi-disciplinary arena. I will attempt to provide evidence of the social worker key skill set and its importance below. In essence, social workers provide:

- Specialist training in legal frameworks, laws, policies and statutory guidance to inform practice decisions, but also to ensure that individuals and carers benefit fully from their legal rights and protections. This is especially crucial in the context of the Mental Capacity Act (2005) and Best Interest Processes where sound, ethical and legally based judgements are required to be made and can also be subject to legal challenge - where ‘we just needed to get them out of hospital as quickly as we could’ does not hold much sway.
- Specialist skills in identifying safeguarding issues in the context of crisis intervention where things may not always be clearly defined, along with the interpersonal skills to sensitively draw out the relevant information at a time where emotions often run high.
- Confidence to challenge – not only other professionals, but the individual and their families themselves, in order to move forward safely and cohesively. This can be seen most clearly during dialogue which involves consideration of positive risk taking, as this can often be contentious due to an unintended focus on protection/safety at all costs, which is enhanced by the artificial hospital environment. Often this leads to workers needing to use their conflict resolution skills and engage in a continued process of negotiation to achieve the best outcomes.
- The ability to see the whole picture and coordinate those findings into an assessment and plan that represents all the things that matter to the person’s wellbeing, not just their medical recovery and physical act of discharge from a hospital bed. This not only results in person centred planning, but when done well, decreases readmission rates by the identification of broader social barriers – such as poverty, isolation, housing issues, access to community – and producing sustainable plans to reduce these.
- The ability to manage complexity within a short timescale – hospital social workers have an incredible level of skill in creating rapport quickly with people, often having to undo trust barriers caused by previous negative experiences, and always at a time when people and their families are recovering from crisis – both physically and emotionally. Often people present as having one set of barriers, but during conversation with a social worker, a far different picture can emerge which needs consideration. Whilst social workers strive to avoid creating dependency, all social workers should be people who those in need can

depend upon, and this is never more needed than in the navigation of complex systems and decisions that can have long term and life changing impacts.

- Use of skills to devise and broker complex care plans and referrals to other specialist services. This also involves ensuing appropriate ‘passing of the baton’ to the onward support mechanisms and services – including making sure that the person and their family do not get lost in this transition. This also involves having in depth knowledge of financial implications and options for people so that they understand the charges they will incur.

In conclusion, I hope that the above illustrates the unique skill set of social workers in hospitals, which in my view blends psychology, law, ethics, conflict management, crisis intervention, relationships, understanding of complex systems and financial implications and at times ‘detective work’, into tangible and sustainable personal outcomes. As the issues facing our society become more complex, it seems only reasonable to match that complexity with workers who have the training, skills, experience and aptitude to meet those challenges head on, with the support of general practitioners to act as a filter to channel demand to the right person at the right time.

Annex 3 - ADSS Cymru Position Paper on NHS Continuing Healthcare (2022)

ADSS Cymru Position Statement on Continuing NHS Healthcare
For Adults in Wales

ADSS Cymru
Yn arwain Gwasanaethau Cymdeithasol yng Nghymru
Leading Social Services in Wales

(May 2022)

The role of ADSS Cymru is to represent the collective, authoritative voice of senior leaders who support vulnerable adults and children, their families, and communities. We offer a professional view on a range of national and regional issues of social care policy, practice, and resourcing. It is the only national body that can articulate the view of professionals who lead-social care services in Wales.

As a member-led organisation, ADSS Cymru is committed to using the wealth of its members' experience and expertise. We work-in partnership with other agencies, to influence the important strategic decisions around the development of health, social care, and public service delivery, benefitting the people the sector supports and those who work to deliver services.

One of our key priorities is to work constructively with Colleagues across all Local Authorities and Health Boards to ensure that the Continuing NHS Healthcare for Adults Framework and Guidance and any related practice guidance (such as Mental Capacity and Best Interest decisions) are universally understood and applied.

Continuing NHS Healthcare (CHC) is a package of care and support, arranged and funded by the NHS, where it has been assessed that the person's primary need is a health need. This is determined by consideration of the nature, intensity, complexity and unpredictability of the need. The care and support to meet these needs is free at the point of delivery (NHS Funded).

Section 47 of the Social Services and Well-being (Wales) Act 2014 states that:
"A local authority may not meet a person's needs for care and support (including a carer's needs for support) under section 35 to 45 by providing for or arranging for the provision of a service or facility which is required to be provided under a health enactment, unless doing so would be incidental or ancillary to doing something else to meet needs under those sections."

Therefore, the Social Services and Well-being Act makes it unlawful for local authorities to provide services which are the responsibility of the NHS.

The last 20 years has seen perhaps more significant advancements in medical care & treatment than any-time in our history. People in Wales are living longer, many with a range of complex medical conditions, which represents a good news story for our citizens. In its initial conception and design, the social care system was not necessarily constructed to meet the needs of people with the increasing complexity of need associated with these advancements. Generationally, there has been a strong emphasis on community-based care and move out of long stay institutions and community hospitals. The expectations of the current generation is very different from previous, which is again welcomed and represents a positive advancement in Wales. Nationally, there has also been a strong drive to move sub-acute medicine and rehabilitation out of hospital sites into communities. There has also been an emphasis to reduce/rationalise the hospital bed base over this time, which needs to be carefully balanced with the increased demand for such services from an ageing population with complex needs. ADSS Cymru are supportive the concept that community services deliver better outcomes for people, however we advocate the need of investment in both NHS & social care community services to develop the capacity needed to accommodate this community approach.

In practice, this approach has contributed to a shift of responsibility from the NHS and inpatient services to social care and community services. District nursing teams have faced long standing pressures with high demands and it is common place for them to delegate activities to care staff that a decade or so ago would have been delivered directly by nurses. Similarly, nursing homes can struggle to attract and retain qualified nurses, leading care providers to accept people with increasingly complex needs with "residential" settings rather than "nursing care". This system shift has occurred gradually overtime and is potentially on an unconscious level. Practitioners are now very familiar with complexity and can consider some things now, to be routine that would have previously considered as complex, this can lead to an unconscious bias for Multi-Disciplinary Team's (MDTs). Moreover, when considering thresholds for continuing healthcare, the potential for scores to be lower than the empirical evidence would suggest that the MDT's can also be led to consider tasks as "social care". It is important to note that the threshold for CHC and the responsibilities of social care in law have not been changed, so we need to work with MDTs to guard against this unconscious drift.

A recent survey in relation to continuing healthcare sent to all Local Authorities in Wales, highlighted areas that are working well and areas that could be improved. The themes from this are included in Appendix 1. ADSS Cymru is keen to work with NHS colleagues to agree a national operating framework which enables us as a health and social care system to provide clarity about the application of the framework and guidance across Wales. This will include ensuring that related processes dovetail with the CHC process, with a particular focus on the following:

- Ensuring that residents make informed choices in relation to consent and understand the implications of declining to the CHC assessment process or subsequent care package.
- Ensuring a common understanding of thresholds for CHC and the limits of social care as defined in S.47 of the Social Services & Wellbeing (Wales) Act 2014.
- Working in partnership to ensure no-one "falls through the gaps".
- Transition from Children and Young People's Continuing Care to Continuing NHS Healthcare for Adults.
- A smooth transition between health and social care that offers the individual and their family as minimal disruption as possible.
- Ensuring equity of access across disciplines.
- Mental Capacity Act and Best Interest decisions.
- Fast-track CHC decisions.
- Interface with Direct Payments and continuity of care.
- Interface with Section 117 aftercare.
- Configuration and role of the Multi-Disciplinary Team.
- Configuration and role of the ratification panel.
- Dispute resolution.
- Best practice in relation to hospital transfer to facilitate right care, in the right place at the right time.

Any change in peoples' health needs can present an extremely challenging time for them and their families. It is paramount that health and social care sectors collaborate to ensure we work in an open and transparent way, getting it right for people who use our services. It is also paramount that we have the right pathways and tools to support our practitioners to work confidently and constructively challenge themselves and other.

ENDS

Appendix 1 - Themes from Local Authority Survey in relation to NHS Continuing Health Care

A survey was circulated to all 22 Local Authorities in Wales to ask them about their experiences in relation to NHS continuing health care, there was a very high response rate and all regions were represented in the returns. Some LA's completed 2 returns due to the distinctly different process they experienced for people who have a learning disability.

What works well about CHC?

Generally, there are good working relationship with MDT members on a day-to-day basis, with good levels of trust at this level.

Discharge to recover and assess pathways work well in some areas.

Most Local Authorities have a lead officer for CHC, most social care staff are aware of triggers for CHC. One area has a shared database for CHC. Another has fortnightly meetings to discuss cases that appear to be CHC related. One area has developed a Standard Operating Procedure for "what makes a good MDT", another has an internal "NICU tool", to work through Nature, Intensity, Complexity and Unpredictability, which informs requests to the local health board for MDT consideration.

Some areas report good links with palliative care teams.

Joint care planning and funding agreements for people who are below the CHC threshold.
Good information sharing between commissioning and long-term care teams in relation to COVID outbreaks, intelligence about provider performance.

Unfortunately, 2 areas reported that it has being difficult to find anything that works well.

What does not work well?

Over time, the pressures within heath care and move to community services has seen an increase in delegation to social care provision from health staff. The complexity of cases held by social care has slowly but consistently increased over the last 20 years; perhaps unconsciously, staff thresholds for complexity have diminished with more & more healthcare tasks seen as routine and delivered under the umbrella of social care.
A lack of consistency has meant that people with different diagnosis are treated differently rather than following the agreed process, is a consistent theme across Wales. For example, there is often a different process and panel for consideration of learning disability, as it is felt less likely for this group to be able to access CHC, if they present with similar needs.

The experience of MDT working is highly dependent on local relationships rather than objective consideration based on the criteria.

MDT decisions are routinely not accepted by Health Board panels and can be overturned.
Social care is often seen as the default, generally there is a lack of understanding of the legal limits of social care, (S.47 Social Services and Wellbeing (Wales) Act 2014) and that needs above this should be met by health regardless of CHC outcomes.

Highlighting the need for CHC consideration seems to fall to social care staff rather than being promoted routinely by health staff. There is also poor communication with the individual requiring care and their families on CHC process and eligibility.

There is no evidence of consideration of the guidance or case law in terms of judgement on levels of care, with some areas appearing to have local thresholds and processes that are not in line with the legislation. Moreover, there is considerable pressure to "just go 50-50" without going through formal process.

The evidence indicated that the CHC fast-track process is not being applied consistently, it was reported that a common reason for rejection of the clinical opinion was that the person was "not end of life", and that clinician opinions can be overturned by Health Board panels.

Timescales for consideration of CHC are often lengthy and fall outside the 8-week timescales. A person can be reimbursed for their contribution, but the Local Authority is not.

The disputes process is not adhered to consistently, in particular MDT / peer review.
There is a lack of understanding of Mental Capacity Act and best interest decision making in relation to CHC, in particular, in relation to direct payments. There have been reports of people being informed that they will lose their direct payment/ carers if they agree to CHC being considered.

Discharge to assess can be negative with people stranded in a care home with long waits for CHC consideration, which can be quicker in hospital as full MDT is "onsite".

There are frequent instances of Health Board commissioners and senior managers attending MDT's and "directing the outcome", including considering the likely provision before the eligibility. There is no clear separation of MDT and commissioning process.

There is an overemphasis on the type of care provision and tasks to be completed, rather than on the persons needs and presenting nature, complexity, intensity & unpredictability.

There are examples of people with "managed needs" not being able to access CHC.
There is a lack of understanding of the interface between CHC and S.117 aftercare (within the Mental Health Act).
There are persistent challenges relating to transition from childcare. Where a person has clear health needs, CHC is often only considered post 18.

What needs to change?

MDTs to work to the framework and case law rather than local interpretation and not to allow decisions to drift either in time or threshold due to numbers of "people with complex needs" on caseloads.

Need to support MDT's to consider CHC as a governance matter and way of ensuring the right level of support is provided rather than thinking of it as a funding stream.

Joint mandatory training that covers CHC, the Social Services and Wellbeing (Wales) Act 2014, including S.47 limitations, the Mental Capacity Act, case law and the interface with S.117 training for meeting chairs.
Trust in MDT decision making and less emphasis / reliance on quality assurance panels.

Fast track process to be followed and medical/nursing professional opinion to be fully accepted to ensure timely support during crisis / period of palliative care - removing the myth of a "person has more than 6 weeks so not eligible" rationale.

Clear separation of MDT decision making from commissioning and cost.

Need for consistency across professionals/ across health board regions / across customer groups and Directorates in particular Learning Disability & mental health, where people should have equal access to CHC. There also needs to be more consistency across Children's and Adult's provision.

Amend legislation to allow Direct Payments for CHC to ensure consistency of worker when the person moves through a Local Authority service to CHC; as the current process is distressing for families and workers.
Active promotion of the right to CHC consideration and support; improved communication with the person and their family and an automatic right to advocacy as part of the process.

Improve the timeliness of response – the Local Authority, as well as person, should be reimbursed if care has been funded and there is a delay.

A clearer disputes resolution process.

A national standard operating procedure or code of practice across all disciplines and diagnosis, to underpin the CHC guidance; in particular, a clear fast track process.
Greater use of regional pooled budgets.

How accessible is CHC within your area

Q 1 Does your health board area promote CHC?
Responses indicate that there is limited evidence that CHC is promoted in Wales; all responses received replied, 'No'.

Q 2 Does your health board operate a single process for CHC or different ones depending on diagnosis / specialism e.g. Learning Disability & Mental Health?
All responses received indicate there is a separate process in operation depending on discipline / diagnosis, and that thresholds are different. This has potential implications under equality duties.

To what extend do you agree with the following statements	
10 point scale ------ 1 = Strongly disagree to 10 = Strongly agree	Average Score
CHC process is straight forward	4
The individual and / or their representative will be given a range of information about CHC in a timely manner before any meetings	4
The individual and/or their representative will be a full party to any decisions in relation to care and support and eligibility	6
The process is normally completed within 8 weeks as per framework	3
Everyone will have the same goal from the MDT consideration	5
The MDT will be unbiased and have mutual respect across organisations	5
The MDT decision will be led by governance, legislation & case law	5
The MDT decision will focusses on finance and who's paying	5
CHC eligibility will be fully considered before considering joint funding	5
The MDT view will be respected and accepted in the majority of cases	5
The MDT decision will be ratified without delay	5
If eligible there will be a seamless transition from social care to health funding	5
If Fast track this will be actioned with delay	3

Threshold for CHC in Wales

The last question of the survey asked if the Pamela Coughlin case for care funding was presented in your health board in your area, do you think she would be likely to get CHC funding?

All areas replying indicated that despite the case law stating that all people with needs similar to, or greater than, Pamela Coughlin, should be eligible for CHC, she would unlikely to be approved by the CHC panel as being eligible for CHC in any area in Wales.