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

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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.

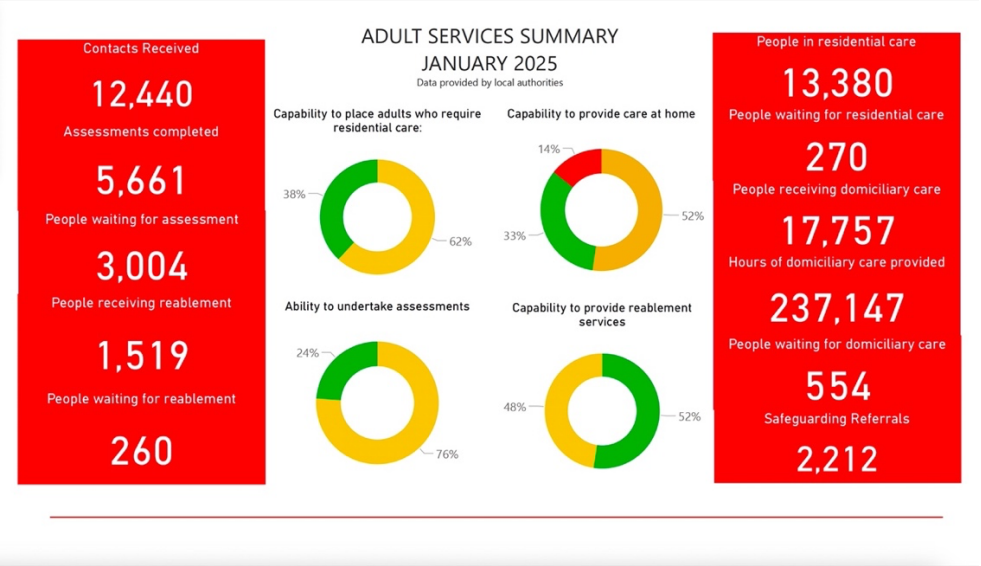
[6] ADSS Cymru/WLGA, *Senedd Cymru Finance Committee: Welsh Government Draft Budget 2025-26* (December 2024).

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.

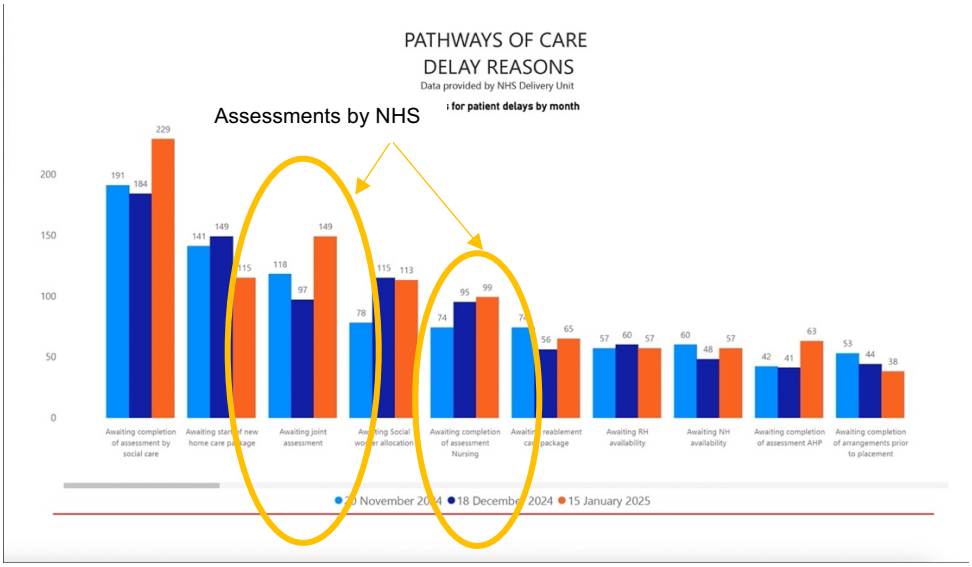
January 2025 Snap-shot



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).



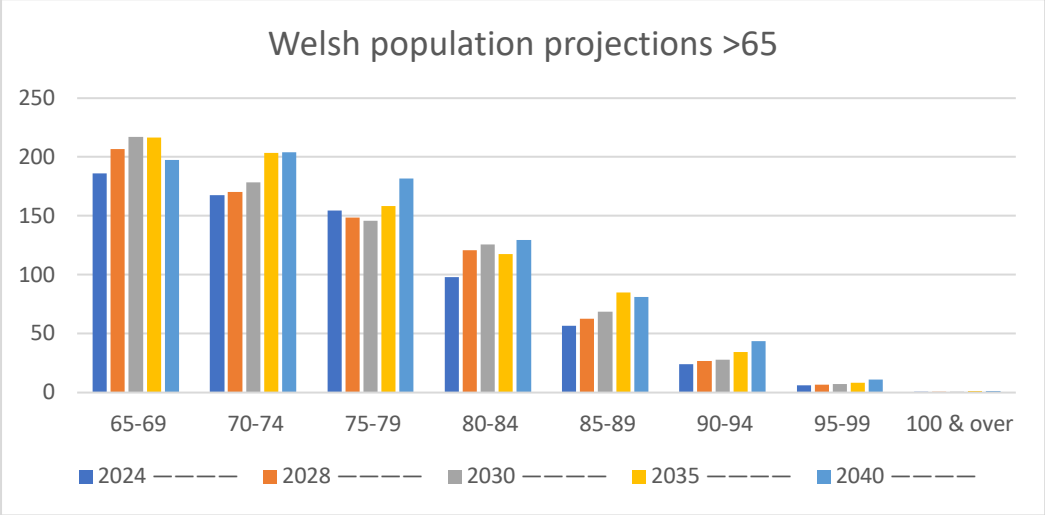
There is often a narrative about assessment delays being "*social care delays*". However, it is important to acknowledge that there are a range of other factors that extend beyond social care. Such delays can also result from issues like patients waiting for nursing assessments, Continuing Health Care (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

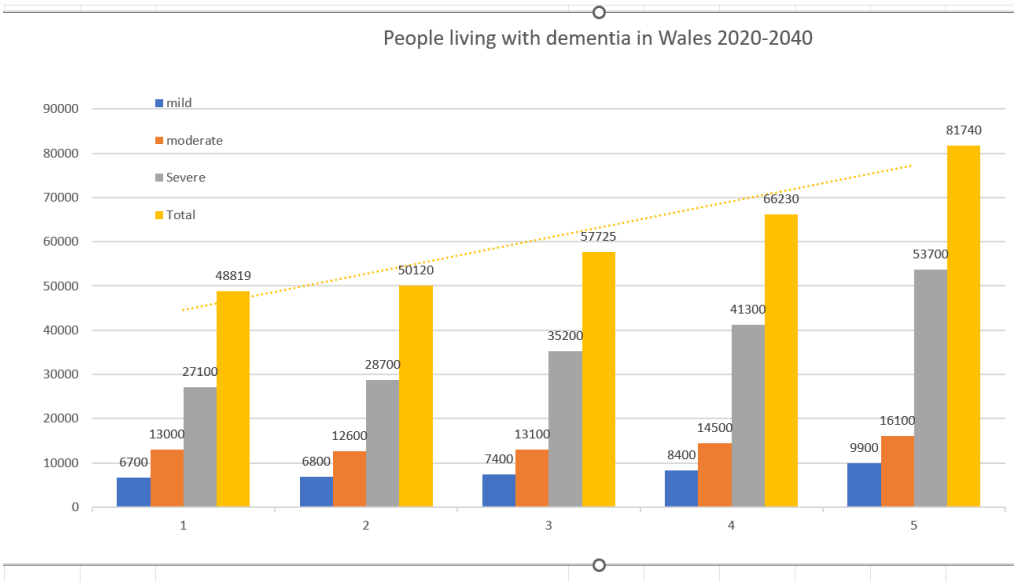
Demographic data indicates an increasing older population in Wales, which is positive for the majority of our population. The Office of National Statistics data shows that mid-2022 there were 1.7 million people aged 85 years and over, making up 2.5% of the population. By mid-2047, this is projected to 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

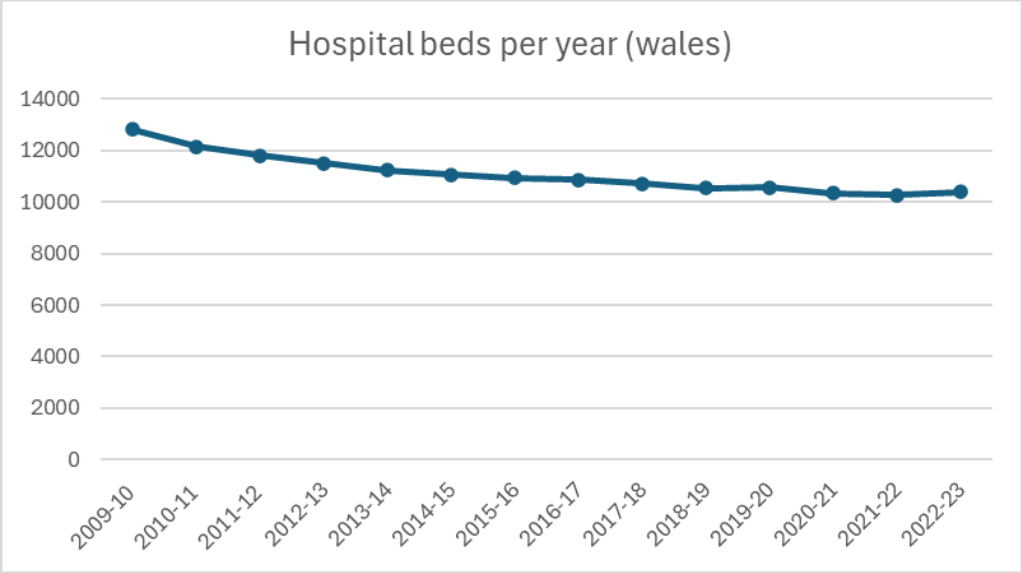
The significant reduction in hospital beds (including mental health and dementia) over last the 15 years

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)

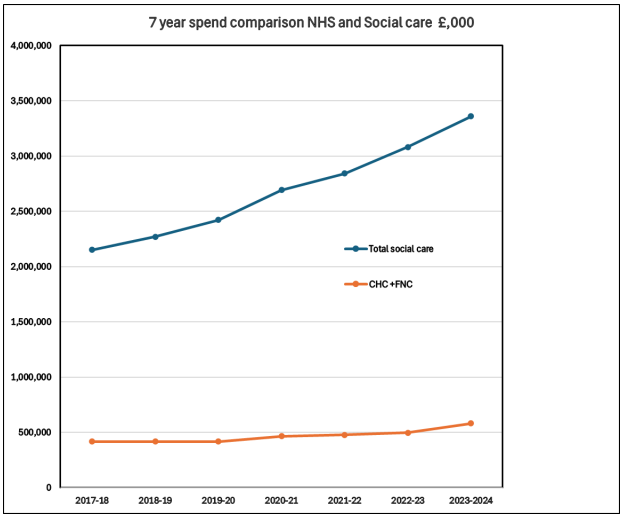
Despite demographic increases and increasing complexity, NHS Continuing Healthcare (CHC) budgets are not increasing to match this demand and in real terms are often reducing. Eligible citizens have a legal right to their entitlement for NHS care. Further, it can increase clinical risks as the wrong professionals 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.