ADULTS SCRUTINY COMMITTEE
7 JANUARY 2025

HOSPITAL DISCHARGES

SUMMARY REPORT

Purpose of the Report

1. To provide Scrutiny Committee with an overview of the requirements on the Local Authority to support hospital discharges and to provide an update on how Darlington is performing on hospital discharges.

Summary

2. In the UK, local authorities (LAs) play an essential role in supporting hospital discharges to ensure people transition smoothly from hospital care to appropriate community or home settings. This involves close collaboration with the NHS to prevent delayed discharges and to support people's recovery and well-being after their hospital stay. Local authorities' involvement in hospital discharges is part of the broader health and social care integration effort in the UK, aiming to provide joined-up, patient-centred care across settings.

3. Below is a summary of the key duties of local authorities in this process:

Assessment and Planning

4. **Needs Assessment:** We must assess a person needs before discharge. This includes determining care, rehabilitation, and support needs.

5. **Discharge Planning:** We must collaborate with NHS staff to develop a discharge plan, ensuring continuity of care by identifying the necessary support services post-discharge.

6. **Integrated Discharge Teams:** Our approach is to work as part of an integrated discharge team with County Durham and Darlington Foundation Trust (CDDFT) to streamline discharge assessments and decisions.

Provision of Services

7. **Community Support Services:** We are responsible for arranging community-based support services, such as home care, reablement (short-term rehabilitation at home), and equipment to facilitate independent living.

8. **Reablement and Intermediate Care:** In cases where people need extra support to regain independence, we provide short-term reablement services, enabling people to recover in their own homes or community-based settings.

9. **Continuing Care Arrangements:** For people with ongoing health needs, we work with the NHS to arrange Continuing Healthcare (CHC) assessments and long-term care placements, if necessary.

Funding and Financial Assessments

10. **Financial Eligibility Assessments:** We conduct financial assessments to determine if people qualify for costs towards their care.

11. **Funding Contributions:** For people eligible we will coordinate payment and support arrangements. Funding can also include temporary "interim care" packages if people are unable to return home immediately.

Supporting Timely Discharge

12. **Collaborating on Discharge Timelines:** We coordinate with hospital discharge teams to avoid “delayed transfers of care” (DTOCs), ensuring people don’t stay in hospital longer than needed.

13. **Discharge to Assess (D2A) Models:** Under this model, we support people to be discharged home (or to an interim setting) quickly, with assessments and care planning taking place post-discharge to prevent hospital bed blocking.

Safeguarding and Well-being

14. **Safeguarding Vulnerable Adults:** We are responsible for ensuring people, particularly vulnerable adults, are discharged to safe environments and that safeguarding measures are in place if necessary.

15. **Mental Capacity and Advocacy Support:** For people who may lack the mental capacity to make decisions, we provide advocacy and make best-interest decisions related to discharge planning, sometimes through appointed advocates or representatives.

Monitoring and Follow-up

16. **Post-Discharge Support and Monitoring:** We monitor people’s well-being after discharge, especially for those receiving community or reablement services, to adapt support as needs change.

17. **Feedback and Quality Assurance:** We are ensuring continuous improvement in discharge practices by gathering feedback from people and families, which is shared with health partners to refine discharge processes.

Key Legislation

18. The Discharge to Assess (D2A) model in the UK primarily operates under the framework of the following legislation and policy guidelines:

Care Act 2014

19. The Care Act 2014 is the primary legislation governing social care in England and outlines the duties of local authorities in assessing and meeting adults' care and support needs.

20. Section 9 of the Act mandates that local authorities conduct a needs assessment for any adult who may require care, which forms the basis of the "discharge to assess" model.

21. Section 2 emphasises the duty of prevention, meaning that we must provide services to prevent, reduce, or delay care needs. Under D2A, we can conduct assessments after discharge to facilitate faster transition out of hospital, aligning with the Act's preventative focus.

National Health Service Act 2006 (as amended by the Health and Care Act 2022)

22. The National Health Service Act 2006 (amended by the Health and Care Act 2022) empowers NHS England and NHS Trusts to collaborate with local authorities in supporting hospital discharges.

23. The 2022 amendments emphasise integration between health and social care, further promoting the D2A model by encouraging partnership approaches to discharge, assessment, and care planning.

Health and Social Care Act 2012

24. This Act underpins integrated care systems and coordination between health and social care, which is central to D2A. It promotes collaborative care and streamlined assessments for patient discharge and care continuity.

Mental Capacity Act 2005

25. The *Mental Capacity Act 2005* plays a role in discharge planning under D2A when people may lack the capacity to make decisions about their care or residence.

26. Local authorities have the responsibility to conduct a best interests assessment for such people, potentially after they are discharged, to determine the most appropriate care setting.

COVID-19 Hospital Discharge Service Requirements (March 2020)

27. During the COVID-19 pandemic, guidance from the UK government on *Hospital Discharge Service Requirements* supported the adoption of D2A as a means to free up hospital beds quickly. This guidance formalised the D2A approach, creating four pathways for post-discharge care and assessment:

    a. **Pathway 0**: Simple discharge with no additional support.
    b. **Pathway 1**: Support in a home setting.
    c. **Pathway 2**: Rehabilitation or recovery support in a community setting.
    d. **Pathway 3**: Support in residential care, for people unable to return home.

28. This guidance, though temporary, laid the groundwork for a formalised D2A approach by emphasising community-based assessments post-discharge.

Health and Care Act 2022

29. This Act introduced further measures for health and social care integration, focusing on hospital discharge improvements. It promotes D2A by encouraging Integrated Care Systems (ICSs) to support more collaborative approaches between hospitals and local authorities for timely discharge and post-discharge assessments.

30. The combination of the *Care Act 2014*, amendments to the *NHS Act*, and *COVID-19 guidance* provides the legislative basis for the D2A model, enabling local authorities and the NHS to assess people' long-term needs in the community, facilitating faster and safer discharges.

Recommendation

31. It is recommended that: -

    a. Scrutiny members note the contents of the report.

    b. Adults Services to provide an annual update to Scrutiny.

Joss Harbron
Assistant Director of Adult Social Care

Background Papers
No background papers were used in the preparation of this report.

Barbara Beadle: Extension: 5125

Council Plan	This report contributes to the priorities agreed in the Council Plan.
Addressing inequalities	There are no implications arising from this report.
Tackling Climate Change	There are no implications arising from this report.
Efficient and effective use of resources	This report supports the efficient use of resources through shared partnership priorities.
Health and Wellbeing	This plan supports priorities set out in the Health & Wellbeing Strategy.
S17 Crime and Disorder	There are no implications arising from this report.
Wards Affected	All
Groups Affected	All
Budget and Policy Framework	There are no implications for the Budget or Policy Framework.
Key Decision	This is not a key decision.
Urgent Decision	This is not an urgent decision.
Impact on Looked After Children and Care Leavers	This report has no impact on Looked After Children or Care Leavers

MAIN REPORT

Purpose of the Report

32. This report provides an overview of:

    a. Darlington demographics and interface with increased demand.

    b. The Hospital Discharge pathway for DBC Adult Social Care (ASC) including Discharge to Assess.

    c. Home from hospital and carer offer.

    d. Performance and data overview.

    e. Current BCF short term funded development- improving experiences and outcomes.

    f. Current transformation plans and ambitions.

Overview

Darlington Demographics

33. Darlington has a growing elderly population, with increasing numbers of people aged 85 and over, who are more likely to require social care. A significant proportion of older adults live with chronic health conditions such as diabetes, heart disease, and dementia, increasing the demand for health and social care services.

34. Within a population of approx. 108,000 *(2021 census)* within borough **818** people are open to ASC aged 65-84 and **502** aged 85+.

35. Demand for Health and Adult Social Care has increased nationally following the pandemic as people were reluctant to seek medical support, alongside difficulties accessing appointments and lengthy delays for onwards referrals and surgeries alongside a significant increase in post viral autoimmune syndromes such as 'Long Covid'.

36. Darlington experiences pockets of social and economic deprivation, which correlates with higher demand for social care services, particularly for older people and those with mental health issues.

37. Life expectancy in some deprived areas of Darlington is lower than the national average; 78.6 male and 82.6 female, leading to increased social care needs earlier in life; 73.1 85.9 male and 76.2 - 90.3 female.

38. The Hospital Discharge pathway for DBC Adult Social Care (ASC) includes the Discharge to Assessment Model, Home from hospital and carer offer.

39. The Responsive, Integrated Assessment and intervention team (RIACT) is based at Hundens Lane. The team have hospital-based social workers who support ward discharge leads with discharge advice, information, and guidance to enable individuals to return home

without/with support. These social workers cover both the Darlington Memorial Hospital and the outlying community hospitals.

40. Referrals are triaged and determined as to whether support aligns to health or social care and at times overlap and joint support provided.

41. **RIACT Adult Social Care** offer includes reablement as well as the hospital social workers and community Occupational Therapists. This forms part of Darlington's integrated intermediate care offer.

42. **RIACT Health** offers community nursing and rehabilitation including physiotherapy and occupational therapy.

Discharge Pathways

43. Government discharge guidance changed frequently during and following the pandemic and following launch of Hospital discharge and community support guidance - GOV.UK in January 2024 ASC developed and implemented an internal *Hospital Discharge (Discharge to Assess D2A) Practice Guidance* launched in June 2024.

Delayed Transfers of Care (DTOC)

44. CQC published their annual report The state of health care and adult social care in England 2023/24 - Care Quality Commission identified where people required Local Authority support to enable safe discharge from acute physical health beds people often experienced delays in allocation, difficulties in sourcing domiciliary care and bed based care resulting in significant Delays in transfer of Care (DTOC).

45. In Darlington we are proud of our hospital discharge offer and rarely experience delayed transfers of care from acute physical health settings. This is due to our positive provider position in terms of capacity, quality and relationships as well as our strong reablement offer and ability to interface with RAPID. Our RAPID and reablement offer supports a D2A pathway.

46. RAPID is an immediate response from a care provider to meet need until a provider can be sourced or reablement aligned. We aim for RAPID to support up to 72 hrs and Making Space is the provider. We block contract 250 hrs per week, and this is flexed when experiencing periods of heightened demand to 300 hrs per week. (Funded via Better Care Fund).

Discharge To Assess (D2A)

47. It is recognised that assessing an individual's needs within an acute health setting does not achieve positive long-term outcomes. Individuals are often medically optimised; able to leave hospital as treatment has concluded but are not well enough to return home and/or require additional support whilst their recovery journey continues. All the discharge pathways are funded for up to six weeks from the Discharge Funding (BCF).

48. This national guidance identifies **four pathways** to support discharge – outlined below with DBC's Adult Social Care ASC and Integrated Health Board's (ICB) offer:

Pathway	Discharge destination	DBC ASC Offer
0	Discharge Home with no support or support of family *No referral received into ASC Identified as simple discharge coordinated by ward staff.*	Hospital based Social Workers to offer advice to discharge leads on ward including assistive technology such as falls detectors and lifeline, onward referral options if needs change as well as signposting to carer support and resources. *It is recognised nationally this is a group that experiences a high level of delayed discharge due to reliant on family to support with appropriate arrangements.*
1	Discharge Home *Referral received into ASC to support discharge*	Supported largely by reablement to support a period of rehabilitation and intermediate care which aims to support people to return to their optimum level of independence. This is a time limited intervention usually up to 6 weeks. Reablement capacity is bolstered with RAPID response hrs (Block contract with Making space)
2	Bed based Intermediate care *No referral received into ASC until discharge planning is needed from these beds*	The ICB contract with Rydal to support this discharge pathway including intermediate care beds, step up beds (to prevent hospital admission) and nursing beds. Additional spot purchased beds are at times required where Rydal criteria isn't met, or capacity isn't available. RIACT Health in reach into these beds and provide therapy to support recovery and rehabilitation. Weekly Multi-Disciplinary Team meetings are held involving ASC and referrals are discussed when appropriate for ASC
3	Nursing care / complex discharges *No referrals received for ASC to support this pathway as led by health.*	Spot purchased beds assessed by health and sourced by the DBC commissioning and brokerage team.

Home from Hospital

49. Supports individuals discharging home from Hospital and is non chargeable and available to those aged 18+ and those individuals who have low level need as the service is not

regulated to provide personal care. The individual will need to live within Darlington. The service can support for a period of six weeks. The provider contracted to deliver Home from Hospital within Darlington is Making Space.

Carers support service hospital discharge

50. This service works closely with adult social care, ward staff and other health professionals to identify and support those who provide informal support to individuals whether this be a new role or existing. The aim of the service is to identify unpaid carers much earlier to improve support for them sooner. The professionals involved will refer prior to hospital discharge and dependent on the unpaid carer the service may provide one to one support up to four weeks post discharge prior to further involvement being provided by the wider Durham County and Darlington Carers Service. The support being offered can range from financial advice including benefits and grants, information and advice, emotional support, and counselling services.

Performance Overview

51. The data table below identifies in the period April-October compared between 2023 and 2024 Adult Social Care have received an increase of 66 referrals (840 in 2024) (774 in 2023). This is an increase of 8.53%.

Month	Hosp Disch
Apr-23	111
May-23	113
Jun-23	109
Jul-23	120
Aug-23	110
Sep-23	106
Oct-23	105
Nov-23	141
Dec-23	113
Jan-24	113
Feb-24	123
Mar-24	134
Total	1398

Month	Hosp Disch
Apr-24	144
May-24	118
Jun-24	109
Jul-24	133
Aug-24	119
Sep-24	86
Oct-24	131
Total	840

52. Data taken from BCF Qtr2 return (June – Sept 2024):

Number of ASC Hospital Discharge Short Stays since Apr24	184
Individuals who have had ASC Hospital Discharge Short stay since Apr24	170
Number of Hospital Discharges to Rapid Response during Apr-Sep24	204

ASCOF 2B – Older people still at home 91 days after discharge from hospital Jul-Sep24	82.1%

53. Number of people supported per month in a period of reablement (up to six weeks):

Month	Apr-Sep23	Apr-Sep24
April	41	45
May	43	33
June	35	32
July	38	36
August	34	36
September	39	22
Total	**230**	**204**

Current BCF short term funded development-improving experiences and outcomes

In-reach reablement

54. The aim is to provide in-reach support from RIACT Social Care to the spot-purchased beds and intermediate care beds to support people home with a reablement approach prior to discharge. Care home staff often deliver from a task-based approach delivering care and 'doing for' whereas reablement 'support with' to support outcomes and optimising independence. This will be delivered through additional capacity for 12 months x1 full-time equivalent Occupational Therapist and 30 hrs Reablement Support Worker.

RIACT early opportunities for review

55. Pressures to review people within short stays following discharge have increased due to the impact of demand and complexity alongside our approach to allocate quickly to support discharge. Therefore, people may have longer stays in short term residential due to the need to provide a Care Act assessment to determine if the ongoing support is required and/or end support. The model within Darlington is currently to provide up to six weeks funded care through the Discharge to assess model. If ongoing support is needed following this a financial assessment is required and assessed client contributions begin from this point.

56. It can be appropriate for individuals to be assessed early within the 'up to' six-week funding timeframe to inform next steps, e.g. short-term residential placement to home with reablement or at times it is clearly known that an individual has reached their optimum and required a longer-term residential placement and therefore the discharge funding alignment can end.

57. We have recruited through the BCF an additional x2 full time equivalent Social Workers (12-month FTC) who will provide additional capacity to undertake the assessments and reviews for people within short stays. They will also provide an additional resource to increased pressures around referrals when needed to prevent Delayed transfers of care and early discharge.

58. This approach aims in turn reduce spend within the Adult Social care budget alongside earlier identification of next steps in an individual's discharge journey with the aim of return home.

Current Transformation plans and ambitions

59. We are currently reviewing the discharge to assess approach in development. The aim will be to enable a proportionate assessment to be completed to support safe discharge identifying specific assessed areas of impendence to enable a measure to be applied at the review. This development also supports an approach of not determining eligibility under the Care Act from an acute health setting.

60. We are working with housing colleagues in DBC to look at opportunities to utilise an Extra Care Housing (ECH) property with the ability to provide short term stays for people unable to return home due to inappropriate housing, awaiting adaptations or no fixed abode to support a period of assessment outside of a bed-based health and/or care environment to determine long term needs and next steps. This is hoped to also provide the opportunity for people to 'experience' ECH and aims to increase onward referrals to this housing and care model.

61. We are working with County Durham and Darlington Foundation Trust to develop a portal to enable online referrals to populate into the client data system to reduce stages of business support and administration time as well as omitting and Data governance risk. This will enable the person to tell their story once, build the quality of the information within the referral and develop further the trusted assessment model.

Outcome of Consultation

62. Not applicable.

Climate Considerations

63. This report has considered climate impact and change. The services leading on the hospital discharges work within the parameters of the organisations corporate plans which incorporate climate change considerations. On individual basis, each team member will work with the person and their families to support a return home where possible. Part of this approach is to assess the home environment for suitable occupancy, energy, lighting, and ability for the person to access their home and local environment. Opportunities to explore sustainable options will be considered by the practitioner.