Health and Adult Social Care Overview and Scrutiny Committee

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Hospital Discharge – Medway Adult Social Care

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Summary

This report aims to inform the Committee of the process of discharging residents supported by Medway Adult Social Care from the hospital setting, our performance in discharging people, and the challenges we are working to resolve.

1. Recommendations

1.1. The Committee is requested to note the report.

2. Budget and policy framework

2.1. This is a matter for the Committee to consider.

3. Background

3.1 Hospital discharge refers to the process of a patient leaving a hospital after receiving necessary acute medical care and being deemed medically optimised to leave and having No Criteria To Reside (NCTR). It involves a coordinated effort to ensure the patient's safe and appropriate transition to their appropriate type of care, whether it's home, a community facility, or another healthcare setting.

3.2 A patient will be discharged along a pathway as illustrated in diagram A below.

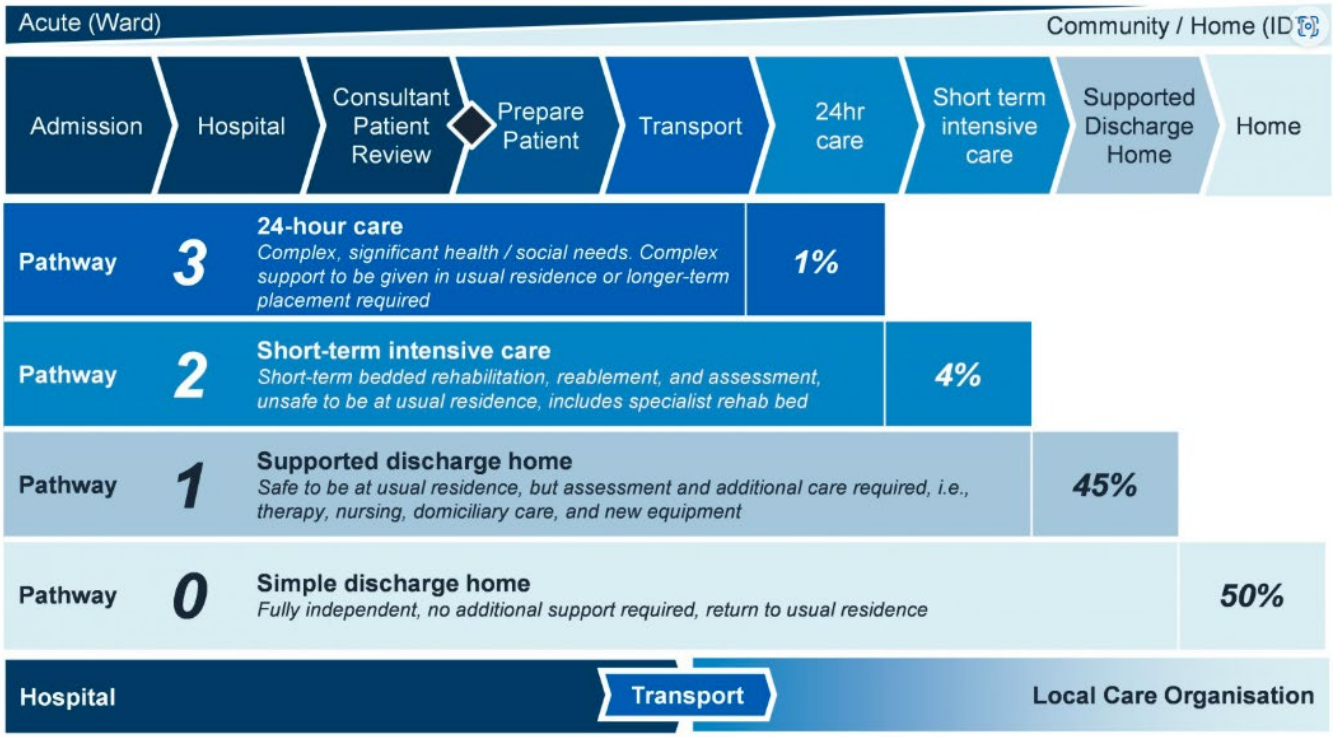

Diagram A Hospital discharge pathways

3.3 At the point a person is ready for discharge from the Acute, Adult Social Care are involved in supporting a number of patients, but not all, on Pathway 1 and Pathway 3 and a very small number, i.e., 1 or 2 a month on Pathway 2.

4. Adult Social Care's responsibilities

4.1 The Health and Care Act 2022 and the Care Act 2014 are the primary pieces of legislation that impact hospital discharge and Adult Social Care (ASC) duties. The Health and Care Act 2022, in part, amended the Care Act 2014, particularly regarding discharge planning and the involvement of patients and carers. It also introduced the duty to cooperate between NHS bodies and local authorities.

4.2 Adult Social Care (ASC) teams support hospital discharge by ensuring the patients they are responsible for receive appropriate care and support after leaving the hospital, which is crucial for a safe and successful transition back into their homes or other suitable setting, i.e. Residential Care.

4.3 They assess care and support needs, coordinate services, and provide information and advice to individuals, families, and caregivers, ultimately fulfilling the duty of care to ensure patients' well-being. In support of hospital discharge, ASC Integrated Discharge Team (IDT)also ensure that patients who have been discharged, under Pathways 1-3, are later transitioned to long term adult social care services following a period of enablement, recovery and/or assessment if applicable.

4.4 Duty of Care:

4.4.1. ASC teams have a legal and moral duty to ensure people eligible for, and in need of care and support, including those being discharged from hospital, have their needs met. This includes promoting well-being, preventing harm, and ensuring safe discharge arrangements.

4.5 Information and Advice:

4.5.1. ASC teams provide information and advice to individuals, families, and caregivers about available services and how to access them. They also support people in making informed decisions about their care arrangements

4.6 Assessing Needs:

4.6.1. ASC teams conduct thorough strength-based assessments to understand a patient's specific needs, including their physical, mental, and social needs. This assessment helps determine the type and level of care and support required after discharge.

4.7 Coordinating Services:

4.7.1 ASC IDT teams work with hospitals and other health and social care providers to coordinate services, ensuring a smooth, safe and seamless transition from hospital to home or another appropriate setting. This may include arranging home care, community support, or accessing other relevant services. Dependent on the pathway identified, ASC conduct either Care Act 2014 assessments to determine eligibility and need, or Trusted Assessor Transfer of Care assessment to support accessing Pathway 2 Discharge to Assess (D2A) provisions.

4.7.2. Discharge to Assess (D2A) beds are short-term placements in care homes or other settings that allow people who no longer need to stay in hospital to be safely discharged while their ongoing care and support needs are assessed. This approach helps free up hospital beds more quickly, supports recovery in a more appropriate environment, and ensures that long-term decisions about care are made in the right setting, rather than under the pressure of a hospital stay. Whilst most patients discharged to these beds are supported by health colleagues, there are assessment beds solely commissioned and managed by Adult Social Care.

4.8 Safe Discharge Arrangements:

4.8.1. ASC IDT teams play a key role in ensuring that discharge arrangements are safe and appropriate for the individual, considering their specific needs and circumstances. This may involve arranging reablement, temporary care or assessing the need for ongoing support.

4.9 Supporting Independence:

4.9.1 ASC teams aim to support individuals in maintaining their independence and quality of life after discharge, helping them to regain the ability to complete activities of daily living or access appropriate support services.

4.10 The Integrated Discharge Team

4.10.1 Our Adult Social Care (ASC) Officers, who are part of the Integrated Discharge Team, are funded in part by the Better Care Fund. However, there are many interdependent services and officers that enable this function which are funded from core council funding.

4.10.2 The team sits within a multiagency / multi-disciplinary team at Medway Foundation Trust. Health colleagues within the team's sole focus is Medway Foundation Trust while working collaboratively with community-based services. However, ASC IDT's scope of work includes all patients with ordinary residency in Medway. As such ASC IDT covers all out of area hospitals, including, but not limited to, Maidstone Hospital, Kings College Hospital, St Thomas' Hospital and Darent Valley Hospital.

4.10.4 ASC IDT has two sub-teams: acute hospital IDT and community-based IDT. Both teams have oversight from one operational manager, one team manager and two seniors, one who oversees acute hospital practice and one who is linked to the social care funded assessment beds.

4.10.5 The IDT Adult Social Care team works under tight time pressures as it is crucial to protect people's health, wellbeing, and independence. Delays can create financial and reputational risks for the Council when social care is linked to long hospital stays. These delays can affect the wider health system by slowing patient flow, reducing available hospital beds, and limiting care for those who are seriously ill.

5. Challenges

5.1 Hospital discharge is a constantly changing environment. Significant delays are often due to the internal flow of the hospital and services delivering care that is beyond the influence of ASC IDT or Brokerage. This, and constraints within the system, means the teams need to be flexible.

5.2 There is a lack of available spaces in the care homes the council works with across Medway. This is especially affecting standard residential care and nursing homes for people with dementia, where providers are struggling to meet demand.

5.3 The process of identifying care and support is often impacted by the increasing cost of placements, with many residential/nursing care providers quoting rates that exceed the local authority's established band rates. As a

result, the IDT Brokerage Team are frequently undertaking price negotiations which creates delays in moving people into care.

5.4 In addition, the IDT Brokerage Team is often required to source care for more complex individuals who may have behaviours that challenge or require enhanced staffing arrangements. In these situations, providers with the right skill set, experience and cost-effective rates must be identified.

5.5 The lack of appropriate social housing also has an impact on a patient's hospital discharge, mostly where patients cannot be discharged back to their accommodation relating to hospital admission, in particular younger brain and spinal injury unit discharges.

5.6 Family disputes cause a delay to discharge for their family members in the hospital. This is mainly where there are capacity issues with a patient who cannot make their own decisions regarding the discharge plans.

5.7 The recently published NHS 10 Year plan has given a new direction for the delivery of NHS services. One element is to create neighbourhood health services which will see some health services move into the community leaving the hospitals to focus on emergency and urgent care only.

5.8 To ensure the process to discharge people from hospital is following best practice, delivering a cost effective and safe service, the Medway and Swale Health and Care Partnership and the Kent and Medway NHS Integrated Care Board are reviewing the discharge function.

5.9 There is concurrently a review of the Transfer of Care Hub which is a focal point for coordinating discharge for people with new or have increased needs who require post-discharge health and/or social care support (pathways one, two and three).

6. Advice and analysis

6.1 Performance June 2024 to June 2025:

6.1.1 Despite coordinated efforts between Adult Social Care and Health colleagues, as described in section 4 of this report, discharge delays can occur when suitable care arrangements are needed to ensure patient safety. These delays reflect growing pressures in the care market and the complexity of individual needs.

6.1.2 Tables 1 and 2 below provide the Committee with information on the number of patients discharged from hospital into residential or nursing care homes under the responsibility of Adult Social Care. They also show the average time taken to source appropriate care, along with the shortest and longest durations recorded over the past year.

MEDWAY HOSPITAL				
Placement Type	**Number of Placements Made**	**Average source Time (approx.)**	**Longest Source Time**	**Shortest Source time**
Standard Residential	11	27 Days	57 Days	1 Day
Standard Nursing	23	16 Days	38 Days	2 Days
Residential Dementia	37	21 Days	84 Days	1 Day
Nursing Dementia	44	35 Days	143 Days	2 Days
Homecare	49	6 Days	22 Days	1 Day
Mental Health Resi/Nurs	Redacted – number under 5	N/A	42 Days	N/A
Respite	Redacted – number under 5	63 Days	118 Days	8 Days
Supported Living	Redacted – number under 5	43 Days	69 Days	37 Days

Table 1 – discharges from Medway Hospital (ASC patients only)

OUT OF AREA HOSPITAL				
Placement Type	**Number of Placements Made**	**Average source Time (approx.)**	**Longest Source Time**	**Shorted Source time**
Standard Residential	Redacted – number under 5	32 Days	43 Days	22 Days
Standard Nursing	7	31 Days	70 Days	7 Days
Residential Dementia	Redacted – number under 5	12 Days	23 Days	2 Days
Nursing Dementia	Redacted – number under 5	11 Days	210 Days	10 Days
Homecare	74	9 Days	51 Days	1 Day
Mental Health Resi/Nurs	7	84 Days	133 Days	48 Days
Respite	0	N/A	N/A	N/A
Supported Living	17	96 Days	199 Days	8 Days

Table 2 – discharges from out of area hospitals (ASC patients only)

6.1.3. As described in section 3.7.1 of this report, a number of patients are discharged from the Acute to Discharge to Assess beds (D2A).

6.1.4 Tables 3 and 4 below provide the Committee with information on the number of people, under the responsibility of Adult Social Care, transitioned from Discharge to Assess Beds to their next type of care (i.e., homecare or residential care). They also show the average time taken to source

appropriate care, along with the shortest and longest durations recorded over the past year.

6.1.5 Delays in moving people on from Discharge to Assess (D2A) beds reduce capacity for new hospital discharges, creating system-wide pressure.

MEDWAY D2A			
Number of Placements Made	**Average source Time (approx.)**	**Longest Source Time**	**Shortest Source time**
13	49 Days	113 Days	10 Days
9	32 Days	90 Days	1 Days
25	27 Days	102 Days	2 Days
13	23 Days	49 Days	4 Days
9	9 Days	40 Days	1 Day
Redacted – number under 5	-	47 Days	-
-	-	-	-
Redacted – number under 5	-	258 Days	-

Table 3 – discharges from Medway D2A beds

OUT OF AREA D2A				
Placement Type	**Number of Placements Made**	**Average source Time (approx.)**	**Longest Source Time**	**Shortest Source time**
Standard Residential	Redacted – number under 5	48 Days	62 Days	33 Days
Standard Nursing	Redacted – number under 5	82 Days	152 Days	1 Day
Residential Dementia	9	28 Days	57 Days	1 Days
Nursing Dementia	26	67 Days	329 Days	1 Days
Homecare	Redacted – number under 5	7 Days	19 Days	1 Day
Mental Health Resi/Nurs	-	-	-	-
Respite	-	-	-	-
Supported Living	-	-	-	-

Table 4 – discharges from Out of Area D2A beds

7. Climate change implications

7.1 There are no additional climate change impacts beyond those associated with a standard discharge process.

8. Financial implications

8.1 There are national targets to discharge people in a timely manner. In times of surge, or extreme pressure, decisions are made to facilitate discharges which will have a higher costs implication.

8.2 These decisions are not always made as a whole partnership, and the Assistant Director, ASC spends considerable time ensuring the mitigation or prevention of these costs.

9. Legal implications

9.1 The Care Act 2014 and the Health and Care Act 2022 are the key pieces of legislation guiding hospital discharge and Adult Social Care responsibilities.

9.2 The Health and Care Act 2022 introduced important updates to the Care Act, particularly around discharge planning. It strengthened the requirement for NHS trusts to involve patients and unpaid carers in discharge decisions as early as possible. It also revoked the previous requirement for long-term care assessments to be completed before discharge, allowing for more flexible, person-centred planning.

9.3 Additionally, the Act reinforced the duty to cooperate between NHS bodies and local authorities, ensuring they work together to support safe and timely discharges and maintain patient flow across the system.

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Appendices

None

Background papers

None