Health and Social Care Overview and Scrutiny Committee – Update on Discharge to Assess Reporting

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Background

- The Hospital Discharge Service Requirements was introduced nationally in March 2020 as a result of the Covid – 19 Pandemic and made a number of key changes to the way Health and Social Care supported Hospital Discharges
- The policy document has been updated over the course of the pandemic and the current version titled Hospital Discharge and Community Support Guidance was published in March 2022 and updated in July 2022
- The collection and reporting of DToC data has been paused nationally since the introduction of the original guidance in March 2020
- The key changes introduced can be summarised at a high level as:
  - A discharge to Assess Model
  - Focus on the Home First Principle
  - Health and Social Care pooling funding to commission discharge to assess pathways

Key Principles

- Prior to the introduction of the guidance a citizen who appeared to have care and support needs had to be assessed under the Care Act in order for their needs to be met on discharge
- For adult social care the time taken to conduct the assessment and commission suitable packages of care was essentially what was being measured by DToC reporting
- Since the introduction of the guidance citizens who appear to have care and support needs are no longer routinely assessed in order to be discharged. They are discharged into one of the discharge pathways where their assessments occur
- Health and Social Care Systems should commission discharge pathways that reflect the local circumstances. Citizens are then able to be discharged into these pathways without any delays for an assessment under the Care Act

Discharge Pathways

- **Pathway 0** – A **minimum** of **50% of discharges** should be via this pathway. These are simple discharges home and do not require new or additional support to get the citizens home
- **Pathway 1** – A **minimum** of **45% of discharges** should be via this pathway. This pathway is for discharges home and includes citizens requiring new or additional support (including intensive support or 24 hour care at home) and should follow the home first principles allowing citizens to recover, receive rehabilitation/reablement
- **Pathway 2** – A **maximum** of **4% of discharges** should be via this pathway. This pathway is for citizens who require a bedded setting for their assessment, recovery, rehabilitation/reablement
- **Pathway 3** – A **maximum** of **1% of discharges** should be via this pathway. This pathway is for citizens with such complex needs that they are likely to require long term 24 hour bedded care following an assessment of their need

Criteria to Reside – Clinically Led

The guidance states that every person on every ward should be assessed twice a day and if the answers to the questions below are no the consideration should be given to discharge to a non acute setting:

- requiring ITU or HDU care?
- requiring oxygen therapy/NIV?
- requiring intravenous fluids?
- NEWS2 greater than 3? (clinical judgement required in persons with AF and/or chronic respiratory disease)
- diminished level of consciousness where recovery realistic?
- acute functional impairment in excess of home/community care provision?
- last hours of life?
- requiring intravenous medication > b.d. (including analgesia)?
- undergone lower limb surgery within 48 hours?
- undergone thorax-abdominal or pelvic surgery with 72 hours?
- within 24 hours of an invasive procedure? (with attendant risk of acute life- threatening deterioration)

Reporting against the criteria to reside

- Reporting against the criteria is health led
- Reporting is aimed at understanding:
  - The timeliness of discharges
  - Performance against target for each discharge pathway
  - Reasons for residing for citizens who meet the criteria to reside
  - Reasons for residing for citizens who do not meet the criteria to reside

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