Supporting Hospital Discharge
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Health and Adult Social Care Scrutiny Panel
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Background

A total of 18,689 hospital discharges have been achieved in Kirklees across both MYT and CHFT since 1st January 2024 to 30 Sept 2024, across discharge pathways 0-3.

Kirklees MDC has 2 Hospital Discharge teams with Social Workers based at Dewsbury District Hospital (DDH) and Huddersfield Royal Infirmary (HRI). The DDH team also support discharges from the Wakefield Pinderfields Hospital and the HRI team support discharges from the Calderdale Royal Hospital.

A total of 1528 Care and support plans have been completed by the Kirklees Hospital assessment teams since 1st January 2024 (to 1st Nov). Adult Social Care Performance is measured in Length of Stay (LOS) once a person is deemed medically fit.

A multiagency approach to discharge undertaken at the daily Integrated Transfer of Care (ITOC) huddles, including social workers, therapists, providers supporting a Home First model of care

LOS performance is difficult to report due to both trusts using separate case management systems. OPTICA is being rolled nationally.

Kirklees Home First Discharge Pathway

Patient reviewed by **Kirklees ITOC Hub** to identify discharge pathway

Home First Challenge = Home is the preferred destination

STEP UP & STEP DOWN

Pathway 0 ***Simple Discharge*** (Carers Count Community Transport / Age UK)	Providing a support offer to Carers post discharge and a transport home/settling in service
Pathway 1 ***Home First Reablement Service*** (Kirklees Council)	Providing reablement and admission avoidance (rapid response) support at home (including night time care and support where needed) for up to 4 weeks, to recover or improve level of independent living
Pathway 2a ***Intermediate Care*** (Locala & Kirklees Council)	Providing person centred rehabilitation to maximise potential and increase independence in bedded unit or own home for up to 6 weeks
Pathway 2b ***Recovery Bed*** (Kirklees Council & Locala; Independent Care Homes)	Providing lower-level rehabilitation in a community recovery bed aimed at people requiring recovery time, those awaiting a package of care (up to 4 weeks stay) and those who are non-weight bearing (up to 6 weeks stay)
Pathway 3 ***Long Term Care/Trusted Assessment*** (Care Homes/Kirklees Care Association)	Providing long term packages of care to patients identified with nursing / EMI residential or EMI nursing need. Supported by Trusted Assessor roles acting on behalf of the care sector to identify appropriate care home placements following Social Care Act assessment

NHS Volunteer Responders

Supported by **Kirklees ITOC Discharge Team**

Kirklees Home First Discharge pathway

Home without any new support **(Pathway Zero)**	The patient is ready to be discharged home without any new support. **Community Transport** and **Age UK** can take patients home from hospital and settle them back in. **Carer Support** can call carers to see how we are doing. **NHS Volunteers Responders** can also provide check-in and chat calls and support with some activities.
Home with new support **(Pathway 1)**	The patient is ready to be discharged home but needs some support at home to help him/her be as independent as they can be. The **Home First Reablement Team** will help the patient be as independent as they can be by supporting them with things like meal preparation and self-care.
Intermediate Care **(Pathway 2a)**	The patient is ready to be discharged from hospital, but not ready to go home yet. He/she needs extra support to regain their independence and will be cared for in an **Intermediate bed** setting until they are safe to go home. The **Intermediate Care Team** will support patient needs in the Intermediate Care bed setting. The patient will receive support from a range of people, including nurses, therapists and carers. Together, a plan will be agreed with the patient based on their abilities, needs and wishes to help them regain their independence.
Recovery Bed **(Pathway 2b)**	The patient is ready to be discharged from hospital, but not ready to go home yet. He/she needs extra support and recovery time and will be cared for in a **Recovery bed** setting until they are safe to go home. The patient will receive support from a range of people, including therapists and carers. Together, a plan will be agreed with the patient based on their abilities, needs and wishes to help them recover and maintain their independence.
Long Term Care **(Pathway 3)**	The patient is no longer able to be looked after safely at home. It is in their best interest to move into a care home. The **Care Home** staff will support the patients' needs. Together, a plan will be agreed based on the patient's abilities, needs and wishes to keep him/her at their best.

Discharge Performance

- 94% of all discharges achieved in 2024 to 30 Sept have been on pathways 0&1- underpinning the Homefirst approach
- Only 6% of discharges have been on pathways 2&3

Kirklees - Total Discharges	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Total	%
Pathway 0- Home (without additional support)	1847	1778	1626	1665	1658	1609	1862	1828	1795	15668	84%
Pathway 1 -intermediate care and reablement services provided in their own homes	223	228	207	197	202	174	233	245	225	1934	10%
Pathway 2 - residential care within the independent and community sector	41	45	45	41	37	49	39	38	35	370	2%
Pathway 3 - nursing care within the independent sector	103	84	82	80	94	74	69	64	67	717	4%
Total	2214	2135	1960	1983	1991	1906	2203	2175	2122	18689	100%

Services Supporting Hospital Discharge and Admission Avoidance

- **Carers Count –** Informal Carers support service
- **Age UK** supported 382 patients home via their Hospital to Home service in NK in 2024
- **Reablement** support 385 people each week from October 2024 (average 3 days from referral to receipt of service)
- **Recovery Bed Hub** at Moorlands Grange now fully staffed (40 beds). Admissions within 48 hours
- **Night Sitting** service fully established
- **Trusted Assessors** working with 60 care homes in Kirklees, 320 trusted assessments undertaken to date. Average time from referral to discharge = 4.5 days
- **Movement & Handling team** – looking to reduce “double up” calls and promote single handed care
- **SCOTS (Social Care Occupational Therapists)** - Primarily an assessment team, identifying needs, agreeing goals and determining interventions
- **KICES –** Kirklees Integrated Community Equipment Services

Carers Count Service

- Simple referrals to Carers Count from any service involved in discharge
- Carer receives: carer lanyard and contact with hospital patient experience team
- Carers Count make contact within 3 days where carer will provide personal care once returning home and no health or care professionals will be in contact with the family following discharge
- Carers Count offer support, advice, information, contingency planning, peer support, and assessment
- Carers Count work with range of partner services including ITOC hubs, social work teams, and discharge lounges to identify new carers
- Family carers have a route to follow up queries after discharge
- 231 carers have been supported since January 2024

Pathway 1 – Home First Reablement

The Home First Service helps people to regain the skills and confidence needed to live independently at home, particularly after an illness or a stay in hospital.

The Home First Service is a short-term service, provided in the home which is offered to people who have the potential to recover or improve their level of independence. This could include:

- Support to practice daily activities such as cooking and bathing to help regain skills and get confidence back
- Finding new ways to do some things to make people feel safer and more confident
- Looking at other options which may help to support independence at home. For example, use of assistive technology, equipment or alterations to the home
- Supporting with therapy plans, if prescribed by a physiotherapist or occupational therapist
- Night-time care and support, providing a full wrap around offer through night visits or night sits
- 0–2-hour admission avoidance where required.

The service is available free of charge for up to 6 weeks.

After 4 weeks, a Care Act Assessment will be completed. The person may require some ongoing care and support to remain at home (e.g. a domiciliary care package, equipment, day-time support, respite for a carer) or the person may require no further support at all.

We are working to 48 hour timescale of accepting people into the service from the point of receiving a referral.

Pathway 2a – Intermediate Care

The Intermediate care service provides support to people for up to 6 weeks in a community Intermediate Care Bed setting or in the person's own home. The team supports people to recover from an episode of acute illness, a fall or operation to maximise their independence and enable them to resume living at home

The bedded unit is provided at **Ings Grove, Mirfield** where the **Intermediate Care beds** are hosted. The unit is supported by a joint team from both Health and Social Care. Personal care is provided by the Social Care staff with health care and rehabilitation provided by Locala clinical Intermediate Care team.

The Intermediate Care team provide 24-hour support and care at Ings Grove. Therapists and care staff work with residents to ensure that they become more independent and can carry out day to day activities. Residents are encouraged to participate in daily rehabilitation. Discussions with residents and families are put in place to plan the person's return home and identify any support needs.

This service may provide home-based intermediate care within the 6-week period to continue rehabilitation, provided that the home is a suitable and safe environment. The Kirklees ITOC Hub may identify some people as suitable for Intermediate Care Support at home, directly on discharge. These patients will have the option to step up into the Intermediate Care Bed setting if required.

We are working to 48 hour timescale of accepting people into the service from the point of receiving a referral.

Pathway 2b – Recovery Beds

40 Recovery beds are based at Moorlands Grange (Netherton, Huddersfield) and provide support to aid post-discharge recovery and allow recuperation time alongside providing a low-level rehabilitation for people not quite ready follow the home first pathway home.

The service also supports people who are awaiting a package of care to go home and those who are non-weight bearing (NWB).

Length of stay in a Recovery bed is expected to be up to 4 weeks (6 weeks for NWB) with an aim to support people to go home earlier if possible, with appropriate support to meet the person's assessed social care and ongoing medical needs in the community.

People in Recovery beds are supported by the Kirklees ITOC Discharge Team who provide an initial holistic assessment within 48 hours of admission.

The team have a daily presence (during the hours of 8am to 5pm) supporting staff and patients to implement personalised care and support plans which encourage reablement.

The team will also support discharge from the Recovery bed setting by arranging any equipment and referrals onto other services for post discharge support.

KICES – Kirklees Integrated Community Equipment Services

Kirklees Integrated Community Equipment Service. This service oversees the equipment budget which is jointly funded by the Council and Clinical Commissioning Group via a pooled budget Arrangement

Collaborative approach and responsive nature of KICES team ensures acute staff can make contact and deal with any issues in the moment ensuring no avoidable delays to discharge