healthwatch East Sussex

Hospital Discharge: Discharge to Assess Beds

Enter and View project to care homes receiving block contract funding for the D2A discharge pathway

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1 Context and aims

1.1 Background

Healthwatch is the independent consumer champion created to gather and represent the views of the public on issues related to health and social care. We have a legal footing set out under the Health and Social Care Act.

One of our statutory powers is to 'enter and view' health and social care establishments and services, to seek the views and experiences of people using them, and to use this feedback to support decision-makers to develop and improve them.

1.2 Context

This enter and view to care homes formed one part of a Healthwatch East Sussex programme of work related to the wider issue of discharge from hospitals. This project is specifically about a scheme entitled 'Discharge to Assess' (D2A).

Discharge to Assess is a national default model for the NHS. Under D2A schemes, planning, assessment, and arranging ongoing care, takes place in the D2A setting rather than the hospital.

The NHS are responsible for identifying the match between a patient and a D2A bed. Adult Social Care are not usually involved at the point a person moves from hospital to a discharge to assess bed. Social workers usually assess the individual's long term care needs once they are at a discharge to assess location.

The NHS are also responsible for determining which pathway a patient takes from hospital. Social workers are available to be consulted where necessary as part of the multi-disciplinary team at the Transfer of Care Hub (TOCH).

We liaised with NHS Sussex Integrated Care Board and East Sussex Adult Social Care who supplied some information about which care homes were being funded by the D2A scheme and how many beds were being funded in each care home. The total number of beds was about 65. The number of D2A beds increases and decreases on a regular basis due to available funding availability, and due to factors such as winter pressures.

The Department of Health and Social Care (DHSC) set out Statutory Guidance on 'Hospital Discharge and Community Support Guidance' updated 26 January 2024. Annex B set out the four pathways under the discharge to assess model. The document states these as:

- pathway 0: discharges home or to a usual place of residence with no new or additional health and/or social care needs
- pathway 1: discharges home or to a usual place of residence with new or additional health and/or social care needs
- pathway 2: discharges to a community bed-based setting which has dedicated recovery support. New or additional health and/or social care and support is required in the short-term to help the person recover in a community bed-based setting before they are ready to either live independently at home or receive longer-term or ongoing care and support
- pathway 3: discharges to a new residential or nursing home setting, for people who are considered likely to need long-term residential or nursing home care. Should be used only in exceptional circumstances

The statutory guidance emphasises the importance of working with families and carers of people in hospital and including them in any discharge process. It also emphasises the importance of a multi-disciplinary approach to the discharge process.

The document states "*Multidisciplinary discharge teams and care transfer hubs, comprising professionals from all relevant services across sectors (such as health, social care, housing, the voluntary and community sector), should work together alongside the person being discharged and their carer or family, where relevant, to plan the person's discharge*."

1.3 Our aim

Our aims were:

1. To obtain feedback from people placed in care homes through the Discharge to Assess (D2A) scheme with particular reference to their journey from their previous place of residence to hospital and then to the care home.
2. To obtain feedback from the management of these care homes as to their views on how the D2A is working, both what is working well and what could improve.
3. Collate the feedback from the above to identify what is working well, what could be improved and make suggestions for the scheme so it has an effective and positive impact on outcomes for people being discharged from hospital.

2 Methodology – What did we do and how?

Through liaison with Adult Social Care and NHS Sussex Integrated Care Board's Commissioning Managers, we obtained the details of the ten care homes that receive placements and funding through the D2A Scheme. Each care home was contacted to discuss the 'enter and view' of their care home to speak to residents placed through the D2A scheme. All agreed to be part of this project and to the 'enter and view' visits.

A questionnaire/prompt sheet was devised so that there would be a consistent approach to the visits and to the meetings with individual residents. A questionnaire form was also devised for our meetings with management at each care home.

A planning meeting was held with volunteers so that all were aware of the purpose of the visits and also to go through the questionnaire/prompt sheet. Two volunteers were allocated to each care home and one of these took on responsibility for arranging a convenient date with the care home for the enter and view visit. Prior to this, each care home was informed of the names of the two volunteers, so they could expect a call from them. All visits were carried out over a two-week period starting from week beginning 27 January 2025.

An analysis of the information provided by the 'enter and view' visits was carried out and a report completed.

A debrief meeting took place for volunteers on Monday 24 February 2025. The themes identified from the analysis of the information were discussed as well as what worked well and what could be improved for any future enter and view projects.

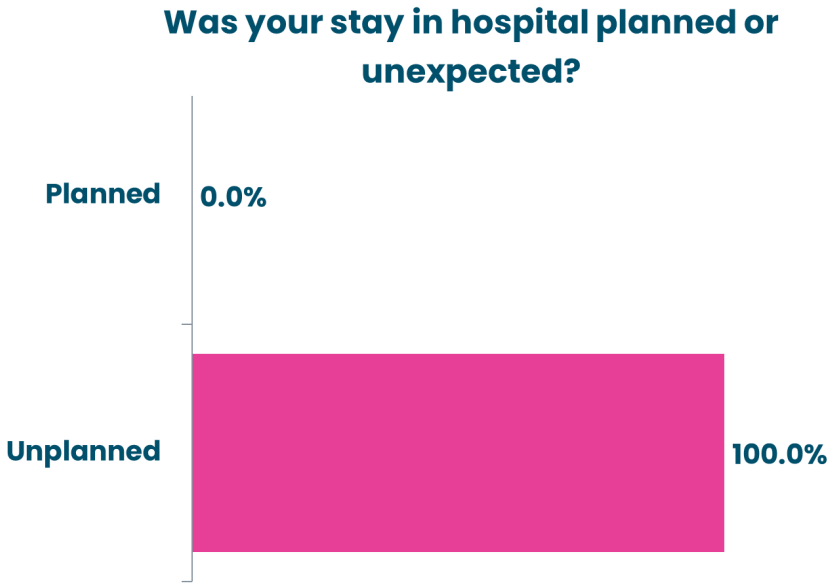
We visited ten care homes and met with twenty-five residents funded through the D2A scheme, about 38% of people bed accessing D2A beds. We met with one relative of a resident, who advocated on their behalf. At each care home we met with at least one member of staff, usually the manager or a senior person within the care home, to obtain their views and feedback.

Of the twenty-five residents we spoke to: 40% (ten people) were discharged from Conquest Hospital; 28% (seven people) were discharged from Eastbourne District General Hospital; 8% (two people) were discharged from Bexhill Hospital; 4% (one person) was discharged from the Royal Sussex County Hospital; and 4% (one person) was discharged from the Princess Royal Hospital. It is not known which hospital the remaining 16% (4 people) were discharged from.

3 Key findings and themes

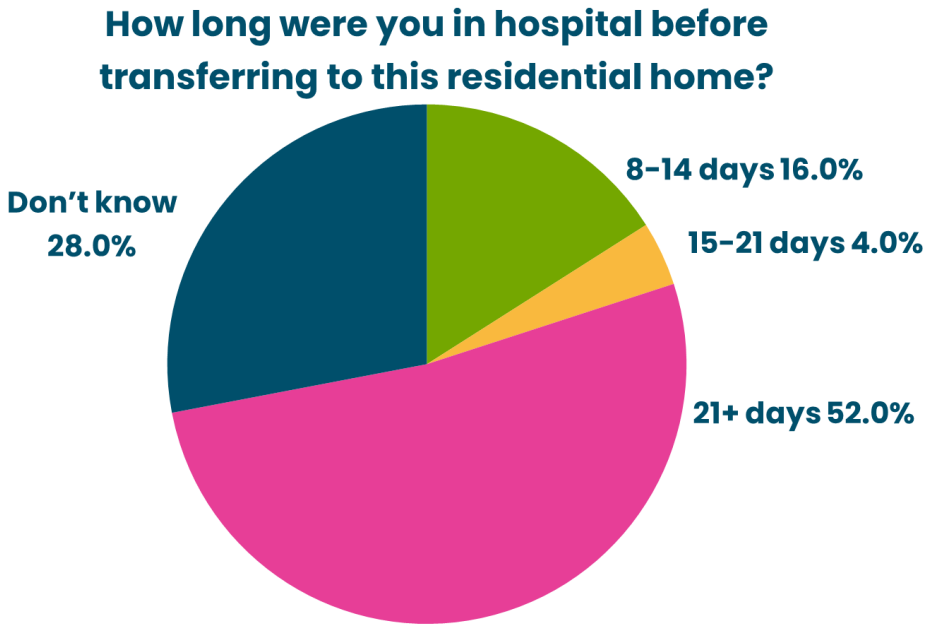
3.1 Prior to admission to hospital

- 96% (twenty-four people) we met with said they had been living in their own home prior to admission to hospital. One person (4%) had been living in an extra care facility. 68% (seventeen people) said they owned their property and the same number said they lived alone. One person was living with their partner and four were living with family members.
- 48% (twelve people) we met with said they were receiving home care support. For nearly all of these people, they were receiving three to four calls daily to support them. 4 % (one person) was receiving help from their daughter. 28% (seven people) said they needed no help or did not receive any help. 28% (seven people) were unsure whether they were receiving support at home or did not say.
- Everyone spoken with said their admission to hospital was unexpected. Some people were uncertain what had happened to result in a hospital admission, possibly as a result of confusion or their physical and mental wellbeing at the point of admission. However, others were clearer. The vast majority of the latter said they had a fall at home and this resulted in an ambulance being called and being taken to the Emergency Department.



3.2 Time in Hospital

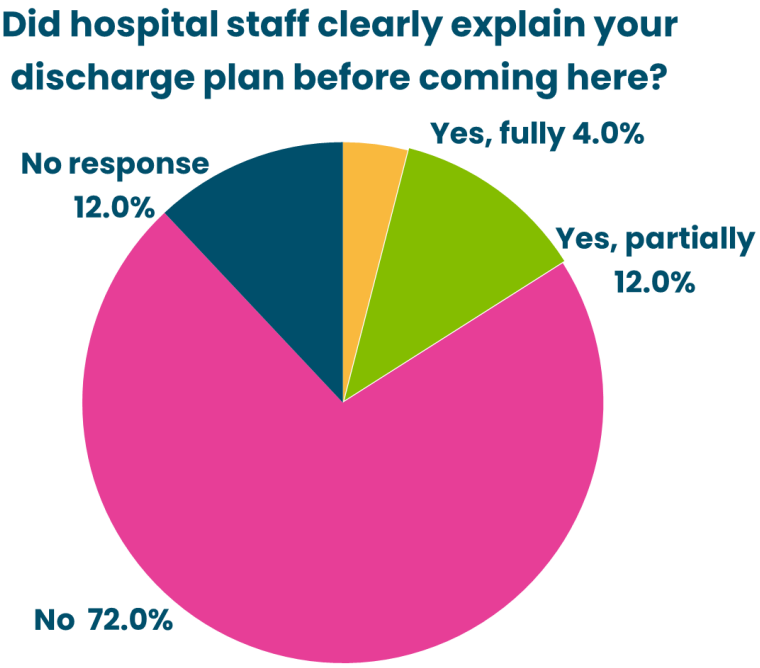
- Many of the people we spoke with were uncertain of the details about their time in hospital. For example, one person told us they do not remember much of his time in hospital and was unable to recall why he had been admitted, or the length of time he stayed there.
- One person said "the people at the hospital were nice". Another said "I did feel safe in hospital with someone there".
- 52% (thirteen people) we met with said they were in hospital for more than three weeks. However, the length of time was sometimes well over this. For example, one person said they were initially in hospital for about eight weeks, then returned home but had to be readmitted to hospital after about two weeks because their mobility was not good, and they were struggling to cope at home. Another person said they had been in hospital for about a year. One person said they had been in hospital for about eight weeks. Another person thought they had been in hospital for about three to four weeks, but staff at the care home confirmed that she had been in hospital for about six months.



- One resident stated that she did not have a good experience in hospital and did not like it at all.
- People were generally unsure about the interventions and support services they received whilst in hospital. However, 32% (eight people) said they had seen a physiotherapist whilst in hospital, two people saw an occupational therapist, two people saw a dietician and one person saw a speech and language therapist.

3.3 Transfer from hospital to care home

- 72% (eighteen people) answered 'no' to the question "did hospital staff explain your discharge plan before coming here?" 4% (one person) said this had been fully explained to them and 12% (three people) said partially explained to them. 12% (three people) did not answer this question.



- As a result of the above, 80% (twenty people) said they had no opportunity to discuss their discharge plan with anyone at the hospital.
- One person said she thought she was going home from the hospital but could not remember whether anyone had spoken with her about going into a care home.
- One person said they only knew they were not returning home when they arrived at the care home. Another person said they did not know where they were being discharged to.
- Another person told us she told the hospital that she wanted to go home but they said she had to go to a care home first.
- One person explained she was taken by ambulance to a care home. She got out of the ambulance and started to go into the care home but was told they were not expecting her. The ambulance crew took her to the wrong care home. Fortunately, they found out the correct care home and took her there. The care home staff confirmed this to be true.

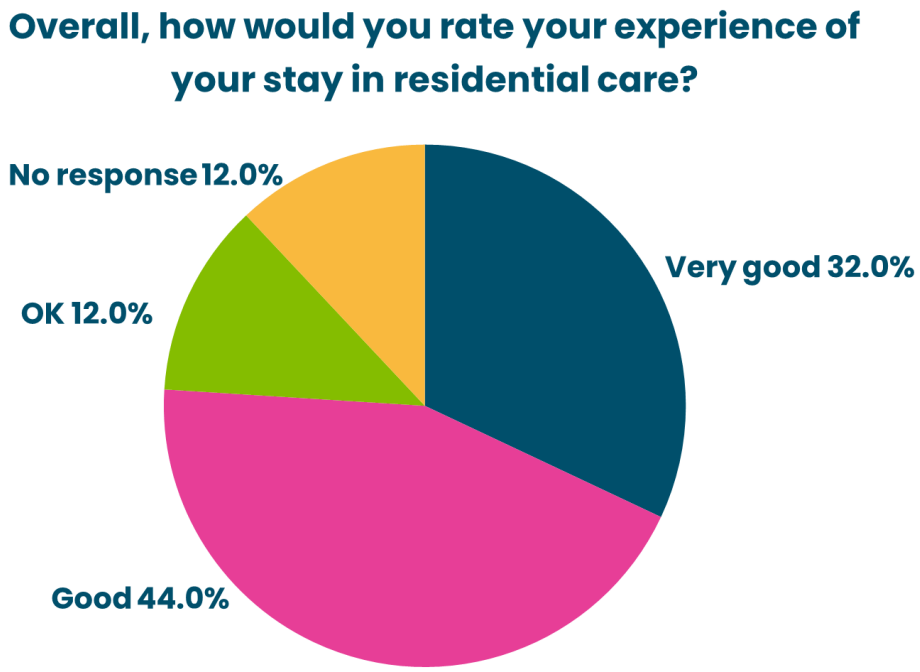
- A relative for one person met with stated there had been no communication from the hospital and they had not been told of his discharge from hospital because they were too busy.
- One person told us social workers did an assessment of her house and told her she could not go home until her accommodation had been deep cleaned. This was in November 2024 and she was still in a care setting in February 2025.
- We were told by one person she had no choice about what care home she was being discharged to and went to one in Bexhill, when her family live in Eastbourne. They find it difficult to visit, as a result.
- One person said the hospital told her a taxi was coming to take her home. She assumed this meant her own home and so was surprised when the taxi took her to a care home.
- Similarly, another person told us they wanted to go home, and he couldn't understand why he is in a care home. Another told us "I wasn't expecting to come here. I was expecting to go home. It was quite a shock".

3.4 Time in the care home

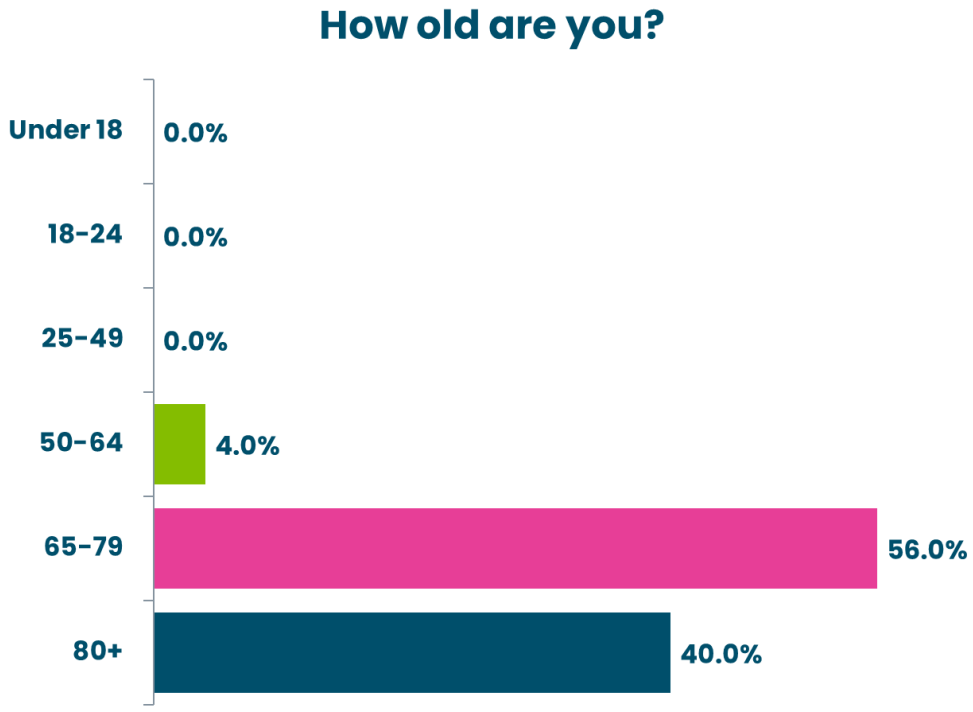
- People were mostly favourable about their stay in the care home. Comments included:
    - "I like it here very, very much" and "nice people here".
    - "I'm well looked after and the food is alright".
    - "The staff have got to know me, so we get on ok".
    - "Staff are very good, although some are young and so still learning".
    - "Food is marvellous".
    - "It's very good here and a carer went to my house to get me some clothes".
    - "I'm being well looked after here".
    - "It's very good here and I want to stay".
    - "I like it here and there are nice people here".
    - "The care home food is better than that in hospital".
    - "The food is horrible but the staff are brilliant".

    - "The home is warm and the food is very nice".
    - "The home is understaffed and not terribly well organised, but the staff are very pleasant and sociable".
    - "I spend my time in my room, but I'm better now and want to go home".
    - "I'm not keen on the lounge as it's too noisy, I like it quiet".
    - "The staff are lovely but the food is not so good".

- 40% (ten people) we met with said a social care assessment had been carried out by a social worker, 12% (3 people) said this hadn't happened and 48% (twelve people) did not know.
- One person said a social worker visits weekly and has met the person's family. She said this had been very good. However, a relative told us she had received no contact at all from a social worker.
- 28% (seven people) we met with said they had seen a physiotherapist and 8% (two people) had seen an occupational therapist. 60% (fifteen people) did not know whether they had seen anyone.
- There was a mixed response in terms of whether anyone had spoken to them whilst at the care home about what happens next. 20% (five people) said that someone had fully talked to them about future plans, 36% (nine people) partially discussed it with them, and 36% (nine people) said no one had spoken to them about this.
- 24% (six people) stated they planned to live in their own home, 4% (one person) in sheltered accommodation and 28% (seven people) in a residential setting. 16% (four people) did not know about future plans at that stage, and the remainder were also unsure about the future although one person hoped to return home with the support of a care package.
- Only 12% (three people) thought their move from the care home had been delayed. Two of these said they were waiting for a social care assessment and the other said there was nowhere suitable for them to go to currently.
- In terms of how they would rate the quality of care and services at the care home 32% (eight people) rated it as very good, 44% (eleven people) as good and 12% (three people) as OK. All four people who had their discharge plan fully or partially explained to them rated their experience of the care home as very good. This suggests there may be a link between involvement in discharge planning and a positive experience of residential care.

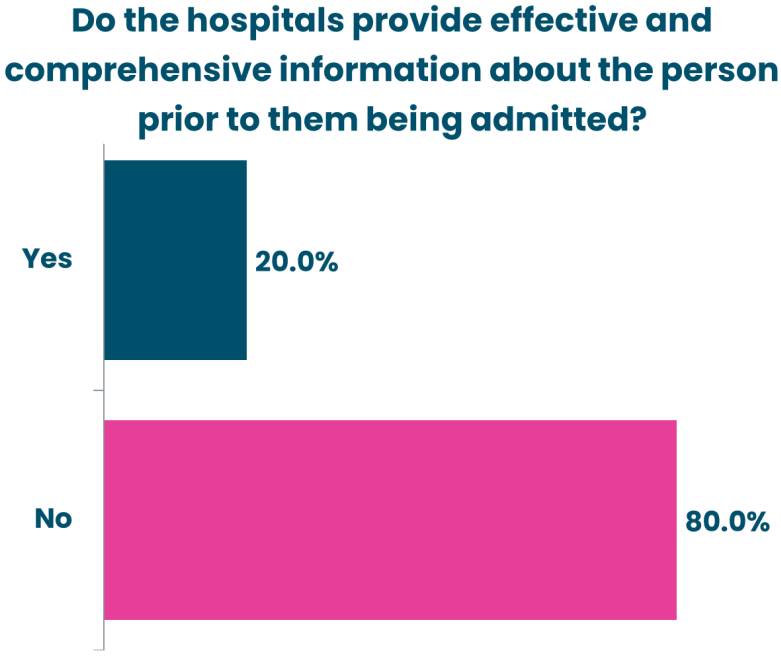


- In terms of the demographics for the people we met with 40% (ten people) were over 80 years of age, 56% (fourteen people) were aged between 65 years and 79 years, and 4% (one person) was under 65 years of age. The Office for National Statistics gives the median age for residents in care homes for older people in 2021 as 86 years and 5 months.



The average age of people residing in the care homes participating in this process indicates a younger age group are in beds funded through the D2A scheme.

3.5 Views of care homes on hospital discharge process



- 80% of care homes stated hospitals did not provide effective and comprehensive information about the person prior to them being admitted to the care home. Feedback included:

    - There is a lack of information in the handover process. There is sometimes conflicting information and a lack of coordination between the ward and the discharge coordinator.
    - The manager told us they receive just basic information.
    - The deputy manager reported that information is very hit or miss. Some information has been blatantly incorrect. There has often been a lack of information about mobility issues and no clear evidence of the risk of falls.
    - They just receive a very brief nurses' assessment. This is often out of date and so provides very little information and information is often not accurate.
    - The nurses' assessment is regularly out of date, not sufficiently detailed and not accurate.
    - Regularly given false information particularly in terms of behaviours and mental health needs. This leads to patients whose needs cannot be met by the home being sent to them. As a result, they are unable to stay there as the home are just not equipped to meet their needs.
    - They receive a nurses' assessment but only a summary. They lack detail and sometimes are quite vague.

- 80% of care homes stated there is no long-term aim for the person being referred to them by the hospital. Comments included:

    - The long term aims for each resident are determined after admission.
    - There has been no social worker assessment for people admitted through this scheme.

- Care homes carry out their own assessments of any person referred to them through the D2A scheme. One manager explained their system. Once they receive a referral, they phone the hospital ward for further information. Sometimes, this will indicate that the care home cannot meet their needs and so do not admit the person. However, if the patient could be a potential admission, they visit the hospital and carry out their own assessment.

  It is at this stage they become aware that the written information provided by the hospital may be out of date and inaccurate. Only once they have carried out their own assessment will they agree to admit the person. There are occasions when they conclude they cannot meet the person's needs and so they do not admit the person.

Case examples – Care home feedback on discharge process

There is often no short or long-term goal known by the care home.

They feel patients are sent to them with almost no information on what the scheme entails and what will happen next. Some patients arrive thinking they are in a permanent placement, and some arrive after being told they were being taken home. It is very distressing and frustrating for patients, their families and the care home.

The D2A scheme is meant to be days to 2 weeks placement, but one person has been in their D2A bed for over 11 months. Patients also have to change to the care homes GP practice when they arrive, even if for a short amount of time, which makes some patients angry as they do not wish to change GP.

- A couple of managers reported that sometimes the hospital will not allow them access to patient records and this limits the effectiveness of their assessment. Where any records are handwritten, access can be easier. However, if information is contained online, access is more often refused.

- 70% of care homes stated people were ready for discharge when they arrived at their D2A bed in the care home. Care homes told us there had been a few re-admissions, often related to behavioural issues or mobility.

- There was a mixed response in terms of whether people had an occupational therapist assessment prior to admission to the care home. 67% said this had not occurred, but 33% said it had.

3.6 Views of care homes once people have arrived

- There was a mixed response in terms of access to health-related services. For example, 50% said they can access a physiotherapist, 40% an occupational therapist, 50% a speech and language therapist and 40% a dietician. Some care homes are able to access the above services from private practices rather than through NHS services.

- One manager reported the home has made referrals for all the above services to support rehabilitation. However, none of these therapists ordinarily come to see people in the home on a regular basis unless the home 'fights' to get support. Another manager made similar comments, stating they must fight to get these services for people, and then they rarely visit the care home to see people, but offer phone advice. The same manager reported that Occupational Therapists (OT) may do an assessment but will not supply necessary equipment, so the care home pays for equipment.

- Another service said they can arrange these services where needed.

- A couple of managers told us that the situation tends to be better when there is a named and allocated social worker involved. This tends to improve the access to rehabilitation services and so speeds up assessments and potentially increase the chances of a person returning home.

Case examples – Access to support services

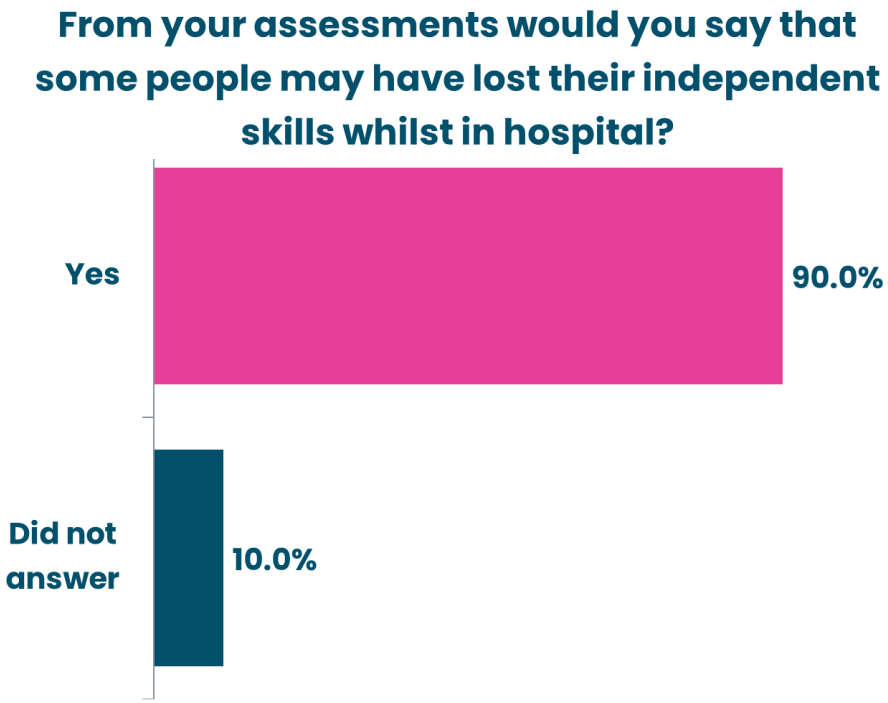
This has varied during the time they have been part of the D2A scheme. Access to these services was very difficult to arrange for most of the time they have taken part in the scheme. This resulted in people being more likely to need long term residential care as they had lost the motivation and the skills for self-caring etc and so this reduces the chance of them being able to manage successful at home.

However, this has changed recently, in the last few months. One social worker has been allocated for the majority of the people placed through the D2A scheme. Whereas, before it could take weeks for a social worker to be allocated, this happens immediately. This social worker has developed effective relationships with the care home and has regular contact with the care home. They visit at least once each week, and often more often.

This has resulted in quicker access to other support services such as OT and physio. This means that rehab takes place sooner than before and this in turn results in a better chance of them being able to return home.

In the past the percentage of people returning home was low and most would need long term residential care. This new system has changed this.

- Nine of the ten care homes told us they thought people may have lost their independent skills whilst in hospital and the other care home did not answer this question. The latter was because they did not know the skills of the people prior to them being in hospital, so felt they could not comment. Some care homes reported people may have reduced levels of independence due to what caused their admission to hospital, such as experiencing a stroke or a major injury through a fall.
- However, one manager reported many people come to them having been in hospital for many weeks, if not months. During this time, they may have lost skills, particularly in relation to mobility. The care home felt that they encourage and support people to get out of bed, mobilise to communal areas etc. and so through these mechanisms improve mobility and independence.
- Some managers felt the lack of rehabilitation services in hospital settings resulted in people being less independent by the time they arrive at the care home and this reduces the chances of them returning home.



- All care homes reported social care assessments are carried out once they arrive at the care home. However, the timescale for the assessments varies considerably. For example, some managers reported it can take place in the first week and at other times it may take several weeks before a social worker is allocated.

3.7 Care homes and what happens next for residents in D2A beds

- The overall conclusion from feedback from care home managers was the majority of people placed in care homes through the D2A scheme remain in residential care, although the numbers varied from one home to another. For example, one care home stated all the residents have remained in residential care in the last year. Another gave a figure of about 50% remaining in residential care. In terms of percentage of people who return home, one care home said that none do so, whilst another gave a figure of about 50%. Others gave a lower figure ranging from about 5% to 25%.

- One care home reported the number of people who return home varies. They stated that having a named social worker for all residents on the D2A scheme has improved the chances of people returning home, as there has been a speedier assessment and better liaison with rehabilitation services. This has resulted in a higher percentage of people returning home. However, prior to this being the case, nearly all people needed long term residential care.

- One manager told us *"almost no one goes home"*. They said most people move to other care homes and with so many people waiting for care packages at home this taking a long time to arrange, which results in people losing their independent skills. They said people and their families become frustrated, as they have been told they may go home, but this either takes a long time to arrange or never happens.
- 60% of care homes reported it is easy to ensure community support is provided once a person returns home. They stated this is usually arranged through the social worker.

3.8 Care homes views on benefits of the D2A scheme

- Each care home could identify benefits of D2A for residents, including:
    - Releasing people from hospital and being able to provide a bit more of a homely environment for patients.
    - The D2A could offer a quicker discharge from hospital.
    - People receive a better level of care in a home than in hospital.
    - The main benefit for patients is they can get out of the hospital environment. People want their own room, and families want a home environment with unlimited access to their family member.
    - Giving residents time in a more 'normal' environment. This helps them reintegrate socially.
    - Often patients want their basic needs met. This means ensuring they receive regular washes and showers, offering a choice of food, as they may have lost weight in hospital, and get their clothes washed.
    - It is a pathway out of hospital and gives the patient and their families a trial run at living in a care home. They may have misgivings about what it is like to be in a care home. They realise it isn't as bad as they originally thought.

- The key benefits to the care home included:
    - Ability to support the NHS and families.
    - The referral stream of patients.
    - The home has gained experience of the hospital discharge process.
    - Increased occupancy.
    - Knowing a set number of beds are paid for, this provides some certainty about bed occupancy.
    - Financial benefits, income we can rely on.

- Care homes provided some feedback on how they thought the D2A scheme could be improved, as follows:

- More effective communication between everybody involved, along the whole pathway.
- One manager suggested that NHS Sussex and Adult Social Care should change the scheme to spot purchase of beds and not block booking beds. They thought the current system was not working and should be scrapped.
- A specific contact is needed for joint working with physiotherapy and occupational therapy. They need to react quicker to get in to see clients, to ensure progress towards going home.
- It would be helpful to have one dedicated social worker.
- Families are not informed where people are going. Families are not informed of the D2A process.
- A more robust assessment would help secure turnover of patients.
- It would help if all equipment and medication were in place in good time for discharge.
- People accessing D2A beds would benefit from better goals and aims. Families are not currently fully informed of the progress.
- More comprehensive, accurate and appropriate referrals. For example, they admitted one person who sadly died within a few days as they were at end of life. The care home felt this was an inappropriate use of a D2A bed.
- Having a clearer assessment of the long-term aim for the person prior to admission to the care home.
- Better communication from start to finish.
- Patients are stuck on wards, deteriorating, it needs to be better for them.
- Would be nice to get feedback from the system on how well they feel we are delivering our work.
- There is no choice offered to patients and so they may go to a place a long way from their own home and their family and support systems. This may affect their recovery and maintaining important links with family.
- The hospitals do not operate in person centred way. For example, sometimes new residents arrive from hospital with nothing, not even any clothes. This can include only wearing a hospital gown. This does not give the person their dignity.
- Patients and their families are given no information about the D2A scheme and the implications.

Case examples – Feedback from one manager

1. More detailed and accurate information at the point of referral from the hospital.

2. Families sometimes only find out that their relative has moved or is about to move into the care home when the latter phones them. So, the hospital needs to ensure that families are involved in the discharge process.

3. A short document setting out details of the D2A scheme and how it operates would be good so that this can be given to patients and their relatives.

4. Some people arrive with nothing, little or no clothes and so the care home needs to contact family etc to try to sort this out. Having systems in place in the hospital so that no one is discharged in this form should be introduced.

5. Any referral to the Joint Community Rehab Team can take up to 3 months and so this means people continue to stay in a hospital or a care home and delays any return home. It also reduces the chances of this occurring and so this needs to change.

3.9 Key themes

1. Communication and sharing information

Feedback provided by residents, a relative and staff at the care homes evidenced that the information given by hospitals to people being placed through this scheme and information given to care homes is inadequate. People told us they were unsure where they were going and why. Some people told us they had been told they were going home but were taken to a care home. One person told us they were in "shock" when they arrived at the care home.

Care home managers told us that information provided to them from the hospital was regularly out of date, incorrect and lacked detail. They carry out their own assessments of the needs of people in hospital, to ensure they were able to meet their needs should they be admitted to their care home.

Some managers reported they felt some admissions were inappropriate. For example, one manager told us a resident had been admitted who was receiving palliative care and they felt this was not an appropriate placement through the D2A scheme.

Managers told us hospitals often would not share information with them, particularly when the information was stored on an online system. Whilst recognising that data protection is important and a legal requirement, it is also recognised that where care is transferred from one registered service to another, there needs to be full information shared between the services, to ensure the transfer of the person between the services is carried out safely.

2. Impact of a lengthy stay in hospital

Residents met with had largely been living in their own accommodation prior to the admission to hospital. Some were receiving home care support to ensure they maintained their independent living. The admission to hospital was unexpected and generally due to having a fall at home. Therefore, none had planned to move into residential care.

In addition, the age of many of the residents we met was below the average age of people living permanently in residential care homes. One person was in his late 60's and was living with Parkinsons. He told us he had accepted he would be remaining in residential care and had recognised he would at some stage have had to accept this, due to his deteriorating health. However, he thought this would be in at least five years' time, rather than now.

Feedback from residents, a relative and staff at the care homes indicated most of the people we met with had been in hospital for more than three weeks. Many told us that they had been in hospital for months, one for at least six months.

No clear picture emerged about the support people received in hospital from specialist services such as physiotherapists and occupational therapists. However, there are indicators which suggest people were not greatly supported to improve their mobility whilst in hospital, as evidenced by the feedback from care home managers.

Care home managers stated many people admitted had lost their levels of independence prior to their admission to hospital. It is uncertain to what extent this is due to a lack of encouragement and support to mobilise in hospitals, or due to the effects of their fall and/or deteriorating health, which resulted in their admission to hospital.

The unclear picture on effective rehabilitation support for people whilst in hospital may adversely affect their outcomes. This, linked with the reported absence of conversations with people about their discharge, may result in no clear goals and aims for the person, and therefore no clear discharge plan. This may contribute to some inappropriate decision-making on discharges through the D2A scheme.

Overall, we heard people's mobility had deteriorated whilst in hospital and this had an impact on their long-term needs and where these could best be met. The conclusion is that without the necessary support, particularly in terms of their mobility and self-caring abilities, people were more likely to have to remain in residential care rather than be supported to return home.

People told us a return home was what they wanted. However, some had accepted that unfortunately they would have to remain in residential care. It could be said that lengthy stays in hospital, and the apparent loss of functional skills, is structuring some people's choices about their long-term care arrangements.

A couple of examples were identified where there did not seem to be any reason for them to still be in residential care. For example, one person told us they had been told they could not return home as their accommodation needed a deep clean. This was in November 2024, about 2-3 months ago. It was unclear why the deep clean had not been carried out so the person could return home.

Case examples – Female resident under 65 years old

One woman told us that she was living on her own with support from carers as a tenant in an extra care scheme prior to her admission to hospital. She was admitted following a stroke. Her discharge timetable stopped and started as the place to which she was being discharged changed before she was told that she could not return to independent living. She commented that the staff in her D2A placement are lovely but she is too young to be in a home, with activities geared to older people. She continued to express her wish to live in supported accommodation.

This person has been discharged into a D2A bed as the Transfer of Care Hub (TOCH) has identified she is likely to need residential care. If it is not possible to meet her goal of returning to live independently with support in the community then Adult Social Care may be responsible for funding her long-term residential placement.

3. **Access to rehabilitation services such as physiotherapy and occupational therapy.**

Feedback from care home managers was that it was not always easy to access these services, despite them being vital to enable people to return home. One care home said they can make private arrangements, however, this is dependent on people being able and willing to pay for these services.

Some care home managers told us there can be a long wait for these services and another said they can only get these services involved if they "fight" to get them.

The conclusion is that without these services being readily available from the point a person is transferred from hospital to care home, then this will limit the options for a resident to return home.

4. Social worker involvement and assessments

Similarly to the above, the same mixed picture emerged in relation to access to a social worker once a person had moved into a care home. The best and most positive situation fed back to us from managers is where there is a named social worker for all people placed through the D2A scheme.

For example, one care home manager reported their social worker is regularly in contact with them, including visiting at least once each week. They are actively supporting the residents to identify what is best for them in terms of future placements and what actions need to take place to ensure these happen. This care home manager stated that when this service is in place, the percentage of people who return home increases. The social worker is able to access services to enable a return home.

However, some care homes stated it can take weeks for a social worker to be allocated and then they are not always effective in carrying out social care assessments to ascertain the best next step. Linked with the noted length of time some people are in hospital waiting to be discharged, and a lack of effective rehabilitation services, the delay in a social care assessment limits the chances of a person being able to return home and may increase the likelihood they will have no choice but to remain in long term residential care.

5. Inappropriateness of some discharges to care homes

Care home managers reported inappropriate placements, for example, some people referred through the D2A scheme had been assessed as at end-of-life.

Care home managers told us some people arrived at the care home from hospital with nothing and only wearing a hospital gown. This is unacceptable.

4 Summary

- ✓ All people met with stated their admission to hospital was unplanned, with many experiencing a fall or accident at home. Therefore, none had anticipated being in a residential setting, with many stating their preferred option would be a return home. Some recognised their situation had changed dramatically and reluctantly accepted they may require long term residential care.
- ✓ It was unclear what rehabilitation services and support people received whilst in hospital. However, people had mostly been in hospital for lengthy periods of time, even up to a year, and so their motivation and abilities to self-care had been reduced.
- ✓ The information provided by hospitals to care homes as part of the admission process was often inadequate.
- ✓ The majority of people referred through the D2A scheme remained in long term residential care.
- ✓ The chances of a person being able to return home were increased where there was an allocated social worker for the care home who worked specifically with the residents placed through the D2A scheme. They had contact with the person soon after their admission and worked proactively and effectively with the care home, the person and their families to obtain the best outcome for the person.
- ✓ Linked with the above, social workers were able to access rehabilitation services quickly compared to situations where there was a delay in allocating a social worker and a delay in identifying and arranging relevant rehabilitation services for the person.

4.1 Further lines of enquiry

This 'enter and view' project has focussed on the 'discharge to assess' pathway, funded by the Sussex Integrated Care Board using part of the 'Better Care Fund.'

It would be useful to survey the experiences of people discharged from hospital on Pathway 1 with a 'home first' approach funded by the 'Better Care Fund'. Healthwatch East Sussex is planning a project to speak to people in receipt of domiciliary care and would welcome the opportunity to work with statutory partners to undertake this project.

5 Recommendations

1. NHS Sussex should consider focussing some resources for the D2A scheme on those people where it is possible that they will be able to return home following a period of reablement and rehabilitation in residential care. The D2A scheme in East Sussex appears to be focussed on Pathway 3, where people are assessed in hospital as likely to need long-term residential or nursing care. The D2A scheme could potentially offer short-term support for people on Pathway 2 to help them recover in a community bed-based setting in residential care. There is a precedent for this reablement approach in West Sussex.

2. A short document needs to be produced by NHS Sussex setting out what the D2A scheme is and how it operates. This would ideally be co-produced with patients, carers and families, as well as care homes. This would be given to patients using the scheme as well as their relatives, so they know what to expect.

3. Nurses' assessments provided by ESHT hospitals and other NHS Trusts need to be carried out at the time of discharge and be in sufficient detail to enable the care home to make a preliminary assessment as to whether it is likely they will be able to meet the needs of that person. A short, one page set format could be devised with key headings, such as any specific health related needs, mobility, diet and mental health issues. This would provide a consistency to the discharge process.

4. The Statutory Guidance referred to in section 1.2 (see above) stresses the importance of a multidisciplinary discharge team as well as the importance of working with the person being discharged and their carer or family. The Transfer of Care Hubs (TOCHs) at ESHT hospitals and other NHS Trusts should ensure that hospital multidisciplinary teams, including social workers, create clear goals and aims for people identified for 'discharge to assess' beds where they may benefit from a reablement approach.

5. East Sussex Adult Social Care and Health should ensure timely allocation of social workers for people being discharged through the D2A scheme, and develop the model of a consistent allocated worker attached to D2A residential providers. This will help ensure that rehabilitation services can be started and/or continued immediately on admission to the care home and a plan for next steps is identified on admission to the care home.

6. NHS Sussex need to align rehabilitation services with discharge to care homes so that therapeutic input can be instigated quickly to maximise the chances of people being able to return home.

7. Healthwatch East Sussex should work with Care for the Carers to highlight the importance of identifying and involving carers in discharge planning, including promoting the NHS Think Carer E-learning developed with NHS Sussex for hospital staff. ESHT and other NHS Trusts should roll out this training to hospital staff to improve the involvement of carers in discharge planning.

As a result of the above, more people will be able to return home and in a quicker timescale than currently the case. This will have a positive impact on the delayed discharges as the turnover in the D2A beds in care homes will be shorter resulting in more people being able to be discharged from hospital. In turn, this will assist in the problem of large numbers of people being medically fit for discharge in hospital settings, but their discharge being delayed.

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