**Hospital discharge responsibilities – funding and case management**

**North Central London Councils’ position statement**

**Version 1 - January 2024**

There has been an ongoing dialogue between the five NCL councils and the ICB regarding funding and case management for various cohorts of people leaving hospital. A short-term solution was put in place for 23/24 but this expires at the end of March 2023.

Previous short-term solutions have been focused on organisations trying to maintain an unwritten “status quo of practice” that arose out of necessity responding to the covid pandemic. This has presented challenges to operational teams in deciding on a case-by-case basis who is best placed to lead and fund discharges, which at times has led to poorer outcomes for residents, such as delays in hospital.

To address this, the Councils have developed a s22 statement and guidance document outlining what social care can reasonably provide in meeting Care Act eligible needs and in what circumstances health needs may be met by social care. Developing a joint statement across the 5 boroughs will help provide consistency of approach for the ICB.

With regards to hospital discharge, we have used the s22 statement and guidance document to identify cohorts that are beyond the limits of social care to provide directly. Brief explanations of the rationale are summarised in pages 3-8 below. There is the potential that Councils can commission care for these cohorts with explicit funding and delegation of commissioning responsibility from the ICB alongside the resident having access to necessary clinical support. This is likely to offer the best value for money and outcomes for residents, whilst supporting strategic market management. This paper sets out the position of the councils with regard to these cohorts with commissioning options.

We are very happy to continue to work with our NHS partners to identify the optimum approach to managing these discharges. To summarise though, without any further agreement the councils will not discharge people from the following cohorts from 1 April 2024:

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| **Cohort** | **Commissioning options** |
| Adults requiring a CHC checklist and / or DST post-discharge | ICB responsibility. Either: * ICB will lead on discharge; or
* ICB delegate funding and commissioning responsibility for some or all of this cohort to the Councils; or
* Checklist and (if required) DST will be completed in hospital.; or
* Alternative arrangement agreed between councils and ICB.
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| Adults with delirium | ICB responsibility. Either: * ICB will lead on discharge; or
* ICB delegate funding and commissioning responsibility for care some or all of this cohort to the Councils; or
* Alternative arrangement agreed between councils and ICB.
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| Adults who are non-weight bearing or who need a collar / brace | ICB responsibility. Either: * ICB will lead on discharge; or
* ICB delegate funding and commissioning responsibility for some or all of this cohort to the Councils; or
* Alternative arrangement agreed between councils and ICB.
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| Adults who only need support with medication | ICB responsibility. ICB will lead on discharge. |

**Responsibilities on discharge when a CHC assessment is awaited**

The Health Act 2006 section 3 (e) & (f) requires ICBs to provide reasonable care for people suffering from illness and aftercare for people who have suffered from illness. An individual should be discharged from hospital when there is no longer a need for them to remain in an acute environment. NHS has ongoing responsibilities to those individuals who remain in need of care or aftercare as a result of illness following discharge from an acute hospital.

Where a CHC assessment is awaited, the responsibility for supporting an individual through recovery and rehabilitation following hospital discharge, lies primarily with the NHS. Local authorities have a role in supporting discharge, but unless the individual’s health needs are optimised and scope of longer-term support is known, the responsibility for funding additional or new needs remains with the NHS until CHC eligibility can be ruled out through the assessment process.

The National Framework for NHS Continuing Healthcare and NHS-funded nursing care (July 2022) paragraphs 101 to 108 sets out the responsibilities of the NHS on discharge to ensure unnecessary stays on an acute ward are avoided. Paragraph 106 states, *“there should be consideration of whether the provision of further NHS-funded services is appropriate. This might include therapy and/or rehabilitation, if that could make a difference to the potential of the individual in the following few weeks or months. It might also include intermediate care or an interim package of support…In such situations, assessment of eligibility for NHS Continuing Healthcare, if still required, should be undertaken when an accurate assessment of ongoing needs can be made. The interim [NHS] services should continue until it has been decided whether or not the individual has a need for NHS Continuing Healthcare.”*

Paragraph 107 of the National Framework provides states that CHC assessments should usually take place in community settings following hospital discharge and sets out the following appropriate pathways as examples:

 *(a) where the individual has an existing package or placement which all relevant parties agree can still safely and appropriately meet their needs without any changes, then they should be discharged back to this placement and/or package under existing funding arrangements. In such circumstances any screening for NHS Continuing Healthcare, if required, should take place within six weeks of the individual returning to the place from which they were admitted to hospital. If this screening results in a full assessment of eligibility and the individual is found eligible for NHS Continuing Healthcare through this particular assessment, then any necessary re-imbursement should apply back to the date of discharge;*

*(b) a decision is made to provide interim NHS-funded services to support the individual after discharge. This may allow individuals to reach a better point of recovery and rehabilitation in the community before their longer-term needs are assessed. In such a case, before the interim NHS-funded services come to an end, screening, if required, for NHS Continuing Healthcare should take place through use of the Checklist and, where appropriate, the full MDT process using the DST (i.e. an assessment of eligibility);*

*(c) a ‘negative’ Checklist is completed in an acute hospital (i.e. the person does not have a need for NHS Continuing Healthcare);*

*(d) a ‘positive’ Checklist is completed in an acute hospital and interim NHS funded services are put in place to support the individual after discharge until it is either determined that they no longer require a full assessment (because a further Checklist has been completed which is now negative) or a full assessment of eligibility for NHS Continuing Healthcare is completed;*

*(e) a ‘positive’ Checklist is completed in acute hospital and a full assessment of eligibility for NHS Continuing Healthcare takes place before discharge. In a small number of circumstances, it may be decided to go directly to a full assessment within the acute hospital, without the need for a Checklist.*

The following guidance sets out additional responsibilities in relation to Hospital Discharge:

* Hospital Discharge and Community Support Guidance (July 2022)

**Responsibilities on discharge when the patient has a delirium**

The treatment and care of someone with delirium is a health responsibility as it is directly as a result of an ongoing illness.

The role of social care is not to treat illness and delirium cannot be described in any other way whilst there is still the potential for improvement.

The treatment of delirium and the care of somebody with delirium are responsibilities of the NHS. One of the biggest risks of delirium in the community is the risk of (re)hospitalisation and this needs to be avoided through carefully managed support with appropriate clinical oversight.

It is not practicable to have a social care assessment on the basis of an acute and generally short-term health need. It is vital that the NHS has effective delirium pathways so that residents get the support they require.

**Responsibilities on discharge when the patient is non-weight bearing or needs a collar / brace**

If the activity required is part of a treatment plan (for example, they can’t stand or can’t move their arms as part of their recovery) then this is treatment and therefore a health responsibility.

Support in these circumstances is about following clinical advice in order for an injury to heal as part of a treatment plan. Social care is not there to support / deliver medical treatment.

**Responsibilities for medication support**

**Medication – only support required**

* Local Authorities have a duty to meet needs for care and support where a person is unable to achieve two or more of the wellbeing outcomes described in the Care and Support (Eligibility Criteria) Regulations 2015 due to illness or disability. This means that medication support alone would not be something which Local Authorities would provide.
* Additionally, medicines support or administration is not one of the outcomes described in the Care and Support (Eligibility Criteria) Regulations 2015 which means there is no statutory requirement for Local Authorities to meet this need.
* The council will not commission a package of care in these circumstances.
* Section 22 of the Care Act 2014 is very clear that a Local Authority should not provide healthcare services which are the responsibility of the NHS to provide under the NHS Act 2006, except where an agreement has been made under section 75 of the NHS Act 2006 (allowing for joint work or pooled budgets).
* Supporting with medication only might be argued as preventative/delaying measure and in as such, our role is to signpost / refer on to health.

**Medication – as part of a broader package of care and support**

* The Care Act 2014 and accompanying explanatory notes do allow Local Authorities discretion (so they are not obliged to do this) to provide some healthcare services where the service provided is a) minor and b) accompanies another care and support service. The Coughlan case (2001) is specifically cited as an example of this “incidental and ancillary test” whereby the provision of healthcare is “merely incidental or ancillary to the provision of the service the Local Authority and is one which they could reasonably expected to provide.”
* In these circumstances, it is acceptable for the support plan to include medication prompting etc so long as it is incidental and ancillary to main tasks in the support plan.
* Care providers need to be registered with CQC to provide this support. Any prompting and / or administration should be accurately recorded; a care provider should have a separate medication policy that includes issues such as client consent, potential use of covert medication, requesting a medication review if concerns arise, etc. The care plan should be very specific if medications are administered.
* Any medication that requires a physical intervention to administer would fall under NHS services.  The only possible exception to this could be emergency medication for such things as severe epileptic seizures where waiting for emergency services is not an option.  This could only be undertaken after staff training from clinicians and be part of an MDT risk management plan.
* If medication support is delegated as an incidental or ancillary health care task, the NHS and in particular, the prescribing clinician, retain clinical governance and are required to assure themselves of the quality and safety of the medication support. The prescribing clinician must take responsibility for any training required by support staff and ensuring the training is kept up to date.