



Department  
of Health &  
Social Care

# Hospital Discharge and Community Support Guidance

Published 31 March 2022

# Contents

About this guidance .....	4
Introduction.....	5
How NHS and local authorities can work together to plan and implement hospital discharge, recovery and reablement in the community .....	7
The care journey.....	7
1. NHS bodies and local authorities should agree the discharge models that best meet local needs that are affordable within existing budgets available to NHS commissioners and local authorities.....	7
2. Planning for discharge should start on admission, or before for elective procedures .....	10
3. People should be supported to be discharged to the right place, at the right time, and with the right support that maximises their independence and leads to the best possible sustainable outcomes .....	11
Structure, roles and responsibilities.....	13
4. Local areas should develop a discharge infrastructure that supports safe and timely discharge to the right place and with the right treatment, care and support for individuals .....	13
5. Joint accountability across health and social care leads to better outcomes.....	16
6. Health and local authority social care partners should support people to be discharged in a timely and safe way as soon as they no longer require acute hospital care .....	20
7. Assessing for long-term needs at an optimised point of recovery improves people's outcomes and is good value for money across the system .....	21
8. Discharge requires active risk management across the system.....	22
Specific needs .....	23
9. Palliative and end of life care needs should be anticipated and met as part of an individual's discharge journey .....	23
10. Information should be shared across relevant health and care teams and organisations across the system in a secure and timely way to support best outcomes .....	24
11. Planning and implementation of discharge should respect an individual's choices and provide them with the maximum choice and control possible from suitable and available options .....	25
12. NHS bodies and local authorities should ensure that, where appropriate, unpaid carers and family members are involved in discharge decisions.....	26
13. Mental capacity, advocacy and special arrangements for discharge.....	27
14. NHS bodies and local authorities should ensure people receive support that is tailored to their specific needs and circumstances .....	29
Annex A - Contributing organisations .....	33
Annex B – Specific responsibilities related to hospital discharge processes.....	34

Annex C – Pathways for the Discharge to Assess Model.....39  
Annex D - Criteria to reside – maintaining good decision making in acute settings ....41

[Section 91 of the Health and Care Act](#) comes into force on 1 July 2022. It revokes procedural requirements in Schedule 3 to the Care Act 2014 which require local authorities to carry out long-term health and care needs assessments, in relevant circumstances, before a patient is discharged from hospital.

Section 91 of the Act also introduces a new duty for NHS trusts and foundation trusts to involve patients and carers (including young carers) in discharge planning. This applies in situations where an adult patient is likely to need care and support after their hospital discharge, and the trust considers it appropriate to involve them or their carers in planning their hospital discharge. The new duty states that this should be done as soon as is feasible after the trust begins making any plans relating to the patient's discharge.

Under this duty, a carer is defined as an individual who provides or intends to provide care for an adult, otherwise than by virtue of a contract or as voluntary work.

More detail about this new duty will be set out in the next update to this guidance, which is expected in autumn 2022.

## About this guidance

This guidance sets out how NHS bodies (including commissioning bodies, NHS Trusts and NHS Foundation Trusts) and local authorities can plan and deliver hospital discharge and recovery services from acute and community hospital settings that are affordable within existing budgets available to NHS commissioners and local authorities. It applies to NHS bodies and local authorities exercising health and adult social care functions in England and should be used to inform local service planning and delivery.

This guidance applies in relation to adults being discharged from acute hospitals and community rehabilitation units in England, excluding maternity patients.

Discharges from mental health hospitals are not within the scope of this guidance. However mental health trusts are encouraged to embed some of the principles, adapted for mental health care pathways. Separate guidance will be published for those being discharged from mental health settings in due course.

This guidance is applicable from 1 April 2022.

## Introduction

From 1 April 2022, local areas<sup>1</sup> should adopt discharge processes that best meet the needs of the local population. This could include the Discharge to Assess, Home First approach. Systems should work together across health and social care to jointly plan, commission, and deliver discharge services that are affordable within existing budgets available to NHS commissioners and local authorities, pooling resources where appropriate.

Under the [Discharge to Assess, Home First](#) approach to hospital discharge, the vast majority of people are expected to go home (i.e. to their usual place of residence) following discharge. The Discharge to Assess model is built on evidence that the most effective way to support people is to ensure they are discharged safely when they are clinically ready, with timely and appropriate recovery support if needed. An assessment of longer-term or end of life care needs should take place once they have reached a point of recovery, where it is possible to make an accurate assessment of their longer-term needs.

Multi-disciplinary hospital discharge teams and transfer of care hubs (see further below), comprising professionals from all relevant services across sectors (such as health, social care, housing and the voluntary sector), should work together so that, other than in exceptional circumstances, no one should transfer permanently into a care home for the first time directly following an acute hospital admission. Everyone should have the opportunity to recover and rehabilitate at home (wherever possible) before their long-term health and care needs and options are assessed and agreed.

This approach reduces exposure to risks such as hospital-acquired infections, falls and loss of physical and cognitive function by reducing time in hospital, and enables people to regain or achieve maximum independence as soon as possible<sup>2</sup>. It also supports hospital flow, maximising the availability of hospital beds for people requiring this level of inpatient care and elective surgery, such as hip replacements.

As health, care and other public services in England move towards more integrated, multi-disciplinary working, local areas have the opportunity to improve the experiences and outcomes of their local population. Local areas should work together to develop the model within existing resources. This should include agreeing any investment to reshape provision towards more home-based, strengths-based care and support, and with less reliance and expenditure on bed-based provision.

---

<sup>1</sup> In this guidance, local areas is used as a collective term for NHS bodies (including commissioning bodies, NHS Trusts and NHS Foundation Trusts) and local authorities exercising functions in England.

<sup>2</sup> Kortebein P, Symons TB, Ferrando A, et al. (2008) Functional impact of 10 days of bed rest in healthy older adults. *J Gerontol A Biol Sci Med Sci.* 2;63:1076-1081

The principles in this guidance should form the foundation for local planning of arrangements for discharge from acute hospitals and community rehabilitation units. This can best be achieved by providing choice for individuals, who should be supported to make fully informed decisions, with input from their wider family or unpaid carers (where appropriate, and where the individual consents) or their Independent Advocate. This process should be person-centred, strengths based, and driven by choice, dignity and respect.

This guidance is based on the experiences of individuals, unpaid carers and organisations with health and care experience, as well as input from leaders of NHS and local government services. In particular, we are grateful for the contributions of Carers UK, the Carers Trust, Healthwatch England, the Local Government Association, the British Association of Social Workers, and the Principal Social Workers Network for their support in developing this guidance. The full list of organisations who have contributed to this guidance is in Annex A.

# **How NHS and local authorities can work together to plan and implement hospital discharge, recovery and reablement in the community**

This guidance has been themed according to:

- The care journey
- Roles and responsibilities
- Specific needs

## **The care journey**

### **1. NHS bodies and local authorities should agree the discharge models that best meet local needs that are affordable within existing budgets available to NHS commissioners and local authorities**

NHS bodies and local authorities should adopt discharge processes that, in their judgement, best meet the choices and needs of the local population. This could include the Discharge to Assess, Home First approach. Funding to support discharge can be pooled across health and social care via an agreement under section 75 of the NHS Act 2006 to minimise delays, ensure effective use of available resources and ensure the decisions about an individual's care needs are made in their own environment. Local areas can choose the appropriate funding mechanisms to enable these processes, such as the Better Care Fund (BCF), or other means that are affordable within existing budgets available to NHS commissioners and local authorities. For example, the BCF can, subject to local agreement, continue to be used to fund services at the interface of the health and social care system, such as intermediate care and hospital discharge planning, as well as core adult social care services and breaks for unpaid carers.

This guidance seeks to support local areas as partners to jointly agree how to use their existing resources to best effect, to deliver the best possible outcomes for their population following the end of the hospital discharge funding. Care, when delivered at home, not only leads to better outcomes for the individual, but is also a better use of resources <sup>3</sup>.

NHS bodies and local authorities should ensure that local funding arrangements are agreed by all partners and are aligned with existing duties, including those under the Care Act 2014 and the Mental Health Act 1983. These arrangements should also include clear

---

<sup>3</sup> Why not home, why not today brochure (local.gov.uk)

information for self-funders of adult social care, so they can make informed choices about any onward care needs that do not fall under locally funded eligible costs.

Health and social care commissioners should consider how capacity across the system is being used to support people in their own homes and consider how resources can be best used to support this.

Where local areas agree to fund a period of care (pending a long-term needs assessment being carried out), agreements should be in place to ensure no one is left without care or – if needed – an assessment of long-term needs prior to the end of this period. This should also ensure that no carers are left without adequate support or an assessment of their longer-term needs (if needed) at the end of this period.

The case studies below set out how two local areas have agreed funding to facilitate best practice for their local hospital discharge services.

Regardless of the hospital discharge, community support and funding model that is adopted locally, people and, where relevant, their families, unpaid carers, and Independent Advocates, should expect to receive personalised support that meets their needs and maximises the person's independence<sup>4</sup>. People should not be routinely discharged to a community step-down bed simply to free a hospital bed, nor should they routinely be discharged to a community bed simply because home-based care is not available. Where relevant, the decision about when to discharge a person, and any support they might need before an assessment of their long-term needs, should take into account the views and circumstances of any unpaid carers as well as those of the individual. Hospital discharge teams should also consider unpaid carers' preferences and involve them to ascertain whether they are both willing and able to provide care and support post-discharge, before an assessment of longer-term needs. This should include an offer to refer to local carers' support services.

If a person's preferred placement or package is not available once they are clinically ready for discharge, they should be offered a suitable alternative whilst they await availability of their preferred choice. People do not have the right to remain in a hospital bed if they do not need acute care, including to wait for their preferred option to become available.

Whilst NHS organisations should seek to offer choice to patients where such choice exists, in practice, there may be limited situations where an NHS organisation may decide to reduce the choice of services offered to people on discharge. Such situations include times of extreme operational pressures, for example, for the duration of the UK COVID-19 Level 4 National Incident. A record should be produced of the considerations of the

---

<sup>4</sup> Individuals may be entitled to Independent Advocacy if they do not have a friend or family member to support them during the discharge process. More information is set out in section 13.



relevant discharging body in deciding to offer that patient a reduced choice, setting out all of the material considerations for and against doing so, and the balancing exercise between the patient choice duty in the NHS Act 2006, and relevant competing duties and countervailing factors. For further information on patient choice, see section 11.

#### Case Study: Surrey County Council (SCC)

Surrey County Council's footprint covers five acute hospitals, and multiple community services across health and care. These services support flow by providing rehabilitation and reablement support post-discharge, as well as directing services towards the prevention of admission. Outside of central hospital discharge funding, SCC have used a combination of the BCF, NHSE services and local authority core funding to deliver their hospital discharge and community services.

SCC have a history in investing in reablement services, and their main pooled funding arrangement is via the BCF. They have multiple place-based reablement teams, and demand is managed across footprints that are coterminous with their NHS commissioning bodies. They have increased capacity in these reablement services by setting them up in partnership with home care providers. Staff operate the same way regardless of who employs them, so the difference in providers is not felt by the individual.

From April 2022, SCC will be continuing their Discharge to Assess services, with some changes. In most cases, they expect ward staff to describe what the person might need, and for the multidisciplinary team in the transfer of care hub to decide which pathway is most appropriate for the person. The majority of funded services will be for people on Pathway 1 and Pathway 2 discharges.

People who would normally fund their own care will be identified in hospital and supported to make informed choices about their care arrangements. If they have a need for a Care Act assessment and an ability to regain skills and confidence in the interim period, they will be given the option to go through the funded reablement pathway. People with health needs, and the potential for gaining skills, may also be supported by community health providers post-discharge.

SCC are exploring setting up a 'risk share fund' with the NHS, via the BCF. This would be used in exceptional circumstances to prevent discharge delays, where a decision cannot be reached about who should fund the individual's interim care support. Finally, they have plans to invest in bespoke hospital discharge services to manage demand. This includes investing in local authority funded step-down services, for people with interim care needs.

## Case Study: South Warwickshire Foundation Trust

South Warwickshire Foundation Trust implemented the Discharge to Assess model as part of a wider system transformation that began in 2012/13 and included: ambulatory emergency care; a community integrated health and social care team; frailty services; trusted assessment; and early supported discharge. The Discharge to Assess approach was rolled out across Warwickshire following a successful pilot.

Joint working is essential to implement Discharge to Assess successfully. The Trust worked with the local authority, NHS Continuing Healthcare (CHC) and the local clinical commissioning groups (CCGs) to set up Discharge to Assess. Joint working between a Warwickshire County Council (WCC)-led Better Care Fund project and local NHS partners reduced delayed transfers of care and provided a strong foundation to respond to COVID-19.

Local authority commissioning expertise is utilised. WCC run the commissioning of Discharge to Assess pathways, with a Joint Executive Commissioning Lead for the local authority based within the trust. Pooled funding via section 75 partnership agreements and memorandums of understanding enable joint decision making, management of risk and clarification of roles and responsibilities.

The Discharge to Assess approach has led to savings for the local health economy with shorter hospital stays for emergency inpatient adults and people over 75, leading to reductions in ward capacity. Discharge to Assess can also lead to a reduction in CHC costs: the Trust's service statistics show that the proportion needing CHC funding with the approach is half that of the group who do not use it. The Trust also found reductions in local authority packages of care and saw less people going into long term care.

Point prevalence studies have proved to be a useful tool. These involve taking snapshot of people within hospitals and community services, asking whether they could be managed in a lower care setting, and calculating the cost-benefit of this.

## **2. Planning for discharge should start on admission, or before for elective procedures**

Planning for discharge from hospital should begin on admission. Where people are undergoing elective procedures, this planning should start pre-admission, with plans reviewed before discharge. This will enable the person and their family or carers to ask questions, explore choices and receive timely information to make informed choices about the discharge pathway that best meets the person's needs. Further detail on the four Discharge to Assess pathways is set out in Annex C.

From the outset people should be asked who they wish to be involved and/or informed in discussions and decisions about their hospital discharge, and appropriate consent received. This may include a person's family members (including their next of kin), friends, or neighbours, some of whom would be considered unpaid carers. Paid care workers and personal assistants may also be included. The person or people identified at this stage, including any unpaid carers, may be wider than a person's next of kin. A person who does not have family or friends to help, or who may find it difficult to understand, communicate or speak up, should be informed of their right to an Independent Advocate.

Multi-disciplinary teams (see section 4) should work across hospital and community settings – including with services provided by community health, adult social care and social care providers – to plan post-discharge care, long-term needs assessments and, where appropriate, end of life care. Social workers, including children's social workers of young carers and young adult carers, should be involved at an early stage of the discharge planning process where appropriate, including where that planning takes place in a hospital setting. The multi-disciplinary team should also ensure that any mental capacity and safeguarding concerns have been considered alongside other support needs post-discharge.

Discharge planning should include information about post-hospital care, such as advice and information about community and voluntary sector organisations, housing options (such as home adaptations and possible alternative housing) and NHS/social care crisis response teams that can be contacted post-discharge.

Family members and unpaid carers providing care for the individual should be offered support where appropriate. For example, all unpaid carers may benefit from signposting to local carers' support services, and they should be made aware of their right to an assessment for their own needs by their local authority<sup>5</sup> (see section 12 for details). This includes young carers under the age of 18.

### **3. People should be supported to be discharged to the right place, at the right time, and with the right support that maximises their independence and leads to the best possible sustainable outcomes**

Health and care professionals who are facilitating hospital discharges should work together with individuals, and – where relevant – families and unpaid carers, to discharge

---

<sup>5</sup> [NICE Guideline 1.2.7](#): Practitioners involved in transferring people to and from hospital should seek to identify carers and refer them to appropriate services.

- Follow recommendations on [support for families, parents and carers throughout admission in NICE's guideline on transition between inpatient mental health settings and community or care home settings](#) **and**
- Follow recommendations on [discharge from hospital in NICE's guideline on transition between inpatient hospital settings and community or care home settings for adults with social care needs](#).

people to the setting that best meets their needs. This process should be person-centred, strengths-based, and driven by choice, dignity and respect.

The vast majority of people being discharged should go home without the need for ongoing support. Of those that remain, the majority of supported discharges should be going home, with only a small proportion of people needing short-term bed-based intermediate care. Only in exceptional circumstances should someone be considered to need long-term care at the point of discharge. See Annex C for further details about discharge pathways.

Support should extend beyond discharge itself. Local areas should have agreed protocols for collaborating with onward care providers about the individual's hospital discharge through the transfer of care hub (see section 10 on information sharing). Community health and care services, including GPs and social care providers, should communicate with the individual and, where relevant, their unpaid carers, to track and manage the individual's recovery, and ensure that any change in the support needs of the individual (or their carer) takes place at an appropriate time.

People should be discharged to a familiar setting where possible, as they often respond well to the familiarity of their home environment when it is appropriate for supporting their needs. If required, they should receive rehabilitation or reablement support from NHS or social care services to enable them to regain their independence as far as possible. This can lead to a more accurate assessment of their future needs once they have reached an improved point of recovery. Practitioners within acute and community health and local authorities should consider a range of factors when supporting the individual and their family, unpaid carer(s) or Independent Advocate to decide an individual's care pathway and post-discharge support. This includes the individual's preferences, existing provision of care, and whether unpaid carers are willing and able to support an individual's recovery. Practitioners should be aware of young carers or young adult carers involved in unpaid support, working with them respectfully and appropriately and ensuring they have necessary support in place.

Discharging people to the most appropriate place to meet their needs requires active risk management across organisations to reach a reasonable balance between safety at all times, and independence. More detail is set out in section 8. Anyone requiring formal care and support to help them recover following hospital discharge should receive an initial safety and welfare check on the day of discharge to ensure basic safety and care needs are met and allow time for fuller assessments to take place as the person settles in their environment. This should be coordinated via the transfer of care hub (see section 4). People should not have to make decisions about long-term care while they are in crisis or in an acute hospital bed.

Local areas should draw upon a range of short and medium-term interim care services, depending on the severity of an individual's needs. For example, some people may benefit from voluntary sector support, or very short term 'hospital to home' services to get them settled back home. Short-term (72-hour) reablement or live-in care services may also be useful to ensure individuals have care available while they settle at home, rather than being discharged to a community or care home bed, but these should be organised and agreed as affordable within existing budgets available to NHS commissioners and local authorities.

People with ongoing mental health needs, a learning disability, dementia, those in the last few months of life, and a range of other factors and conditions may require specialised support in the community to ensure their needs continue to be met. Children and young people facing the loss of a family member, and anyone facing the loss of a loved one due to suicide, should be informed about how they can access specialist bereavement support. The needs of homeless people will also need to be considered (see section 14). Local commissioning plans should include the provision of specialised support that meets the local population's needs.

## **Structure, roles and responsibilities**

### **4. Local areas should develop a discharge infrastructure that supports safe and timely discharge to the right place and with the right treatment, care and support for individuals**

Local areas should develop and implement the hospital discharge model that best meets the needs of their local population that are affordable within existing budgets available to NHS commissioners and local authorities. Discharging an individual onto the right care pathway when they no longer need to remain in hospital requires a whole system approach. NHS organisations should work closely with adult social care, children's social care, care providers, housing, the voluntary sector and others to ensure people's care and treatment is timely, optimal and coordinated, while also minimising delays when they are ready to be discharged.

Senior level support from NHS providers and local authorities should provide strategic leadership and oversight of the discharge process to monitor and eliminate the causes of unnecessary discharge delays and ensure that the agreed hospital discharge procedures are being followed consistently.

NHS bodies, local authorities and other relevant partners should develop local protocols. These should set out each organisation's role and how responsibilities should be exercised to ensure appropriate discussions and planning concerning a person's short and long-term care options happen at the appropriate time in their recovery.

To ensure hospital discharge processes are effective, NHS bodies and local authorities should also ensure local recovery, rehabilitation and reablement services are commissioned effectively and sustainably, and meet the needs of their local population in the short and long term that are affordable within existing budgets available to NHS commissioners and local authorities. This may be provided as part of intermediate care services, and should be done in collaboration with relevant organisations, including the voluntary and community sector and care providers.

The support needs of specific populations should be considered when commissioning local services (see section 14). This includes determining the type of specialist rehabilitation services needed for people with complex conditions and ensuring appropriate social work provision and other specialist support is in place for people in complex, abusive or neglectful relationships. The involvement of advocacy should also be a key consideration where appropriate. Local areas should also determine the best working arrangements of multi-disciplinary health and care teams who manage discharge from acute and community hospital settings, whether they choose to co-locate their staff, work together using virtual systems, or find other means of effective collaboration.

Commissioners should work with local voluntary and community sector organisations to develop and maintain capacity in the community to support people, including those who do not need specific reablement or rehabilitation, to retain links into the community and maintain their wellbeing.

#### Specific roles, structures, and responsibilities

Health and social care systems based around a hospital should have an identified executive lead, employed by any partner in the system, to provide strategic oversight of the discharge process. They should ensure that appropriate procedures are followed, including the inclusion and support of carers, and that there are no avoidable delays to discharge.

Every local health and social care system should have a single coordinator who acts on behalf of the system to secure safe and timely discharge on the appropriate pathway for all individuals. This system leadership role can be employed by any partner in the system. Their primary function is to develop a shared system view of discharge, hold all parts of the system to account and drive the actions that should be taken as a system to address shared challenges. The single coordinator is accountable to the executive lead.

Every local health and social care system based around an acute hospital footprint should have a transfer of care hub whereby (physically and / or virtually) all relevant services across sectors (such as health, social care, housing and voluntary sector) are linked together. The transfer of care hub should coordinate care for people who require formal care and support after discharge from hospital, and any support for unpaid carers

providing care. Hubs should be staffed by a small team, dedicated to ensuring people are discharged from hospital on the right pathways, with the right discharge information, and that they get the right onward care and support (if needed). Staff based in the transfer of care hub may also be the care givers and rehabilitation professionals for an individual. Decisions about what long-term support package is needed should not be taken on the hospital ward.

Case managers in transfer of care hubs should link relevant services to coordinate care and support the individual. The case manager can be from any discipline (such as social care, primary care or therapies) depending on the needs of the individual being supported. They should also make arrangements for all persons leaving hospital with ongoing health and care needs to have an initial safety and welfare check on the day of discharge to ensure basic safety and care needs are met and allow time for fuller assessments to take place as the person settles.

Hospital multidisciplinary teams should describe – with input from the person and their unpaid carer, advocate, or relevant community-based professionals – the needs that require support after discharge before an assessment of their long-term needs. This could include non-clinical factors like their physical, social, psychological, financial and practical needs, including home adaptations and equipment. This could determine whether the person's home is suitable for their needs upon discharge. Multidisciplinary teams may include social workers, clinicians, therapists, mental health practitioners, pharmacists, care workers, dietitians, housing representatives, volunteer and community services and any other specialists needed to coordinate care for the individual. They should adopt strengths-based and person-centred planning, working together to plan care and carry out joint assessments. These teams should be aware of carers' rights, and ensure carers are willing and able to care and that they have sufficient support to care safely. This helps to facilitate an integrated transition from hospital to the person's usual place of residence. Safety should be ensured from the day of discharge. They should refer those requiring support to the transfer of care hub.

Hospital-based social workers have a vital role as members of a multi-disciplinary team, ensuring a person-centred and strengths-based approach is adopted during pre-admission, hospital stays and planned safe discharge. Their role in hospital and assessment settings is essential for people whose social circumstances are complex. These social workers should be experienced in supporting people to make informed choices, weighing up the risks and benefits of options, and they should be familiar with mental health, mental capacity and safeguarding issues. They should also be knowledgeable about carers' rights. They should understand the full options available to people in community settings in order to offer people the best choice and understanding of their recovery pathway.

It is critical that General Practice and other primary care providers are directly linked into all discharge planning to ensure that health recovery support is available to the individual throughout their care journey.

Detailed guidance on accountability and roles can be found in [staff action cards](#).

## 5. Joint accountability across health and social care leads to better outcomes

### Cooperation duties

[Section 82 of the NHS Act 2006](#) requires NHS bodies and local authorities to cooperate with one another to secure and advance the health and welfare of their local population. NHS bodies and local authorities must also comply with duties in the Care Act 2014, which requires them to co-operate with each other in the exercise of their respective care and support functions, including those relating to carers and young carers (section 6 and 7).

### Best practice

To implement best practice, NHS bodies and local authorities should work together to:

- determine what an individual needs and wants after discharge, if anything, so that they are discharged onto the pathway that best meets their needs
- appropriately refer qualifying individuals to Independent Advocacy services on admission, so their voice is heard during the discharge planning process
- plan, commission and deliver appropriate care and support that meets population needs and is affordable within existing budgets available to NHS commissioners and local authorities
- understand the quality, cost and effectiveness of local treatment, care, and support to inform people of their options
- understand the role each organisation has in safeguarding and put appropriate safeguarding policies and procedures in place<sup>6</sup>

---

<sup>6</sup> The [NHS Safeguarding App](#) is available as a free resource and aims to keep you updated on safeguarding and trauma informed practice (Level 1 & 2). Further information on safeguarding can be found in the following intercollegiate documents:

- [Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff](#)



- take joint responsibility for the individual's and unpaid carer's, including young carer's, welfare when making decisions about discharge and post-discharge support
- transfer people seamlessly and safely from hospital to their own home or new care setting with joined up care, via clear, evidence-based and accurate assessments that fully represent the medical and psychological needs and social preferences of the person
- transfer information between settings in a timely way
- identify any carers, including young carers, and determine whether any carer is willing and able to provide care and, if so, what support they might need (including through use of young carers' needs assessments)

### **Planning, delivery and monitoring of discharge services**

Local areas should agree governance structures that support clear planning, delivery and monitoring of performance and routes to escalate issues, where required. They should work together to:

- agree expected levels of performance, including the establishment of performance management mechanisms to monitor and improve outcomes
- use agreed, reliable and shared data to inform daily decision making, address issues and improve outcomes for people being discharged
- agree an executive lead and a single co-ordinator for the system
- establish and implement a joint vision and ambition for an approach, maximising the numbers who are discharged home
- implement mechanisms to plan, deliver and monitor the effectiveness of local discharge and recovery/rehabilitation arrangements
- Seek proactive feedback from providers of care post discharge on how the discharge went in practice, and identify areas for improvement
- identify joint commissioning responsibilities and leadership

- 
- [Looked After Children: Roles and Competencies of Healthcare Staff](#)
  - [Adult Safeguarding: Roles and Competencies for Health Care Staff](#)

- establish how shared risk and resources will be managed in order to deliver improved outcomes for people being discharged from hospital in a way that is affordable within existing budgets available to NHS commissioners and local authorities

### **Legal duties on health and social care bodies**

Health and social care providers must meet the requirements set out in [the Health and Social Care Act 2008 \(Regulated Activities\) Regulations 2014](#):

- Regulation 9 provides that the care and treatment of people using services must be appropriate, meet their needs and reflect their preferences.
- Regulation 12 provides that care and treatment must be provided in a safe way. To comply with this regulation, care providers must, amongst other things, assess the risk to people's health and safety of receiving any care or treatment.

[Care Quality Commission \(CQC\) guidance](#) for providers on meeting the 2014 Regulations states that providers must assess risk to people's health and safety, including during the discharge process, and that such risk assessments must be completed and reviewed regularly by people with the qualifications, skills, competence and experience to do so, and should include plans for managing risks.

The [Care Act](#) 2014 sets out a single route to establishing an entitlement to care and support for adults with eligible needs for care and support, and the entitlement to support for carers. The Act is also clear about the steps that local authorities must follow to work out this entitlement, and to help people understand the process. This includes a duty to assess and meet people's eligible care needs in relevant circumstances and to conduct a financial assessment where necessary.

[Section 2 of the 2014 Act](#) and [section 3 of the 2014 Act](#) require local authorities to take steps to prevent, reduce or delay needs for care and support for local people and with a view to ensuring integration of care and support services with health provision, including the provision of housing. Section 2 requires local authorities to have regard to identifying carers with needs for support that are not being met.

From 25 March 2022, the Coronavirus Act will be repealed. NHS bodies and local authorities should adopt discharge processes that best meet the needs of the local population. This includes assessing the person's longer-term needs at the right time, in the most appropriate setting. This should be achieved through joint working across health and social care including pooling of resources where appropriate. The government is working to underpin these principles through legislative changes being proposed within the Health and Care Bill by revoking Schedule 3 of the Care Act, which requires long-term health and

care needs assessments to take place before discharge from hospital, which can delay discharge.

NHS England and CCGs must comply with their duties in relation to NHS Continuing Healthcare and NHS-Funded Nursing Care, as set out in the [National Health Service Commissioning Board and Clinical Commissioning Groups \(Responsibilities and Standing Rules\) Regulations 2012](#), whilst having regard to the [National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care](#).

The CQC monitor, inspect and regulate services to make sure they meet fundamental standards of quality and safety. The fundamental standards set in law a clear baseline below which care must not fall, and the CQC will be able to take enforcement action against providers that do not meet these standards.

NHS bodies and local authorities should ensure all legal responsibilities are met in relation to mental capacity and best interest decision making, and in relation to people's [entitlement to aftercare services](#) following discharge from detention under the [Mental Health Act 1983](#).

NHS bodies also have a duty to refer a person who is homeless, or may be threatened with homelessness, to local authority homelessness/housing options teams under the requirements of the [Homelessness Reduction Act 2017](#). More detail is set out in section 14.

Specific responsibilities of NHS bodies and local authorities in relation to hospital discharge are set out in detail in Annex B.

## **Escalation**

Health and social care systems should have escalation mechanisms for people with concerns about care and support that are clearly communicated to people using services, their families, their unpaid carers and advocates, and service providers. These should clearly set out who is responsible for what and at which step of the process they should be engaged.

Concerns should be escalated via the locally agreed escalation mechanism, overseen by the single coordinator reporting to the executive lead. Areas will have flexibility over how this is implemented locally, but they should ensure mechanisms are agreed with all partners, and that there is a clearly identified responsible person at each stage of the discharge process. Escalation mechanisms should be co-designed with people, including carers, who have experience of escalating issues in the past to ensure they work.

Where a complaint needs to be raised against an NHS body, it should be made to them directly in the first instance. This can be done through the relevant body's complaints

department, or its [Patient Advice and Liaison Service](#) (PALS). PALS can also provide information about the NHS complaints procedure, including how to get independent help if needed. Where a complaint needs to be made by an individual or provider this should be raised directly with the NHS body providing the service in the first instance. A complaint can also be raised with the commissioner of the service. Where this does not yield satisfactory results, the complaint can be raised through the [Parliamentary and Health Service Ombudsman](#).

Where a complaint needs to be raised against a local authority or care provider, it should be made to them in the first instance. If this does not yield satisfactory results, or the complaint is not answered within a reasonable time, a complaint can be raised through the [Local Government and Social Care Ombudsman](#).

Individuals can also provide information to local Healthwatch organisations and the CQC, which may carry out a range of actions including inspecting the relevant body if it has the powers to do so.

## **6. Health and local authority social care partners should support people to be discharged in a timely and safe way as soon as they no longer require acute hospital care**

Health and social care professionals should support and involve the individual to be discharged in a safe and timely way to ensure they are only hospitalised for as long as they require hospital care. Discharging people once they no longer need acute care improves their outcomes and reduces the risk of medical complications such as deep-vein thrombosis, hospital acquired infections, and loss of independence<sup>7</sup>. Evidence suggests that even 10 days of bedrest is associated with significant muscle loss in older adults<sup>8</sup>.

The criteria to reside tool (see Annex D) was developed in March 2020, as a response to the first wave of the Coronavirus pandemic. It is being reviewed with the collaboration of the British Geriatric Society and a broad set of clinicians to ensure it supports clinical teams to have discussions and make decisions whether a person needs to stay in an acute bed to receive care.

No person should be discharged until it is safe to do so. This should include ensuring that, where relevant, any unpaid carers have been consulted on whether they are willing and

---

<sup>7</sup> Rosman, M., Rachminov, O., Segal, O., & Segal, G. (2015). Prolonged patients' In-Hospital Waiting Period after discharge eligibility is associated with increased risk of infection, morbidity and mortality: a retrospective cohort analysis. *BMC health services research*, 15(1), 1-5. Tess, B. H., Glenister, H. M., Rodrigues, L. C., & Wagner, M. B. (1993). Incidence of hospital-acquired infection and length of hospital stay. *European Journal of Clinical Microbiology and Infectious Diseases*, 12(2), 81-86.

<sup>8</sup> Kortebein, P., Symons, T. B., Ferrando, A., Paddon-Jones, D., Ronsen, O., Protas, E., ... & Evans, W. J. (2008). Functional impact of 10 days of bed rest in healthy older adults. *The Journals of Gerontology Series A: Biological Sciences and Medical Sciences*, 63(10), 1076-1081.

able to provide care and support. Young carers should be offered independent advocacy support if they want it, to support them to consider how they will be impacted.

The [2018 National Audit of Intermediate Care](#) indicates that intermediate care recovery services over a 6-week period increases levels of people's independence and can reduce the number of preventable readmissions to hospital. The audit found that 71% of individuals reported an improved dependency score after a 6-week period of home-based care. 85% reported an improvement after 6 weeks of bed-based care, and 66% for reablement care. As a result of rising levels of independence, we would expect fewer emergency readmissions and long-term social care needs, including a reduction on cost pressures. Hospital readmissions are estimated to lead to [additional costs of £1.6bn annually](#). While this figure indicates the total cost of hospital readmissions for all reasons, Discharge to Assess can help lower some of these costs if the necessary recovery services are in place after hospital discharge.

## **7. Assessing for long-term needs at an optimised point of recovery improves people's outcomes and is good value for money across the system**

Individuals should be assessed for their long-term care needs following a period of recovery, rehabilitation and reablement (where required) when they are back in a familiar environment. The assessments should take place at a point of recovery when their long-term care needs are clearer.

Local authorities have duties to assess and meet people's eligible care needs in relevant circumstances and these assessments should be conducted in a timely manner, in accordance with their Care Act 2014 duties. Best practice is for these assessments to be undertaken in a person's home to determine long-term care needs.

If care, treatment or support is needed, the individual should be fully involved in considering what form that might take and in weighing up the risks and benefits of the options that are available. This includes, if required by the person, consultation with family members and any carers who are willing and able to provide care and support. If the individual does not have any friends or family members to consult with about these options, then an Independent Advocate should be consulted.

Social care expertise is a central part of the process to determine people's long-term care needs following a period of recovery and rehabilitation. It can maximise their independence, meet their needs and wishes and ensure they are fully aware of their options and the implications of each choice.

For individuals leaving the acute hospital environment it is best practice to screen for NHS Continuing Healthcare at the right time and in the right place for that individual. In the vast majority of cases this will be following discharge and after a period of recovery at home. Further information on how hospital discharge interacts with NHS Continuing Healthcare can be found in the [National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care](#).

People with end of life needs will have additional considerations, which are set out in [section 9](#).

## **8. Discharge requires active risk management across the system**

Multi-disciplinary discharge teams should work together when discharging people to manage risk carefully with the individual, and their unpaid carer, representative or advocate, as there can be negative consequences from decisions that are either too risk averse, or do not sufficiently identify the level of risk. At one end of the scale, people may be discharged onto pathways which result in care being over-prescribed; and at the other end, individuals may not receive the care and support they need to recover. Any onward care providers should be included early in the person's discharge planning. This allows more time for local capacity to be managed and suitable support to be put in place. People's care needs may also change, and there should be processes in place to ensure these needs are continuously reviewed and that the person is receiving appropriate support (see [section 4](#)).

[A study of 10,400 individuals' care pathways](#) found that of the people who experienced a delayed discharge, 32-54% were discharged to a setting where the levels of care were not suitable for their needs. 92% of these people were receiving more intense care than they needed, suggesting a barrier to them maximising their independence.

Individuals and local factors will determine how best to manage risk. For example, in areas covering a broad geography, a virtual transfer of care hub may be one model that can facilitate multidisciplinary working to ensure information about individuals and any family or friends caring for them is shared effectively across organisations with their consent. Other areas may choose to co-locate key staff members from relevant organisations at a physical transfer of care hub, such as in a local acute hospital. Alongside ensuring integrated working across health, housing, social care and other key organisations, assigning a single point of contact ensures that the individual or the family can communicate with professionals in a timely manner. Unpaid carers, in particular young carers and young adult carers, should be told how to communicate their concerns to professionals. This could be particularly crucial if there were a change in the individual's care needs post-discharge, such as their condition worsening. Supporting multidisciplinary

working is also key to developing a shared approach to risk to support discharge. Huddles, trusted assessment, shadowing, and peer learning can all support this.

Health and social care professionals working in NHS bodies and local authorities should ensure that 'safety netting' is provided whereby the individual is provided with advice on discharge. The person should be given the contact details of their discharge team at the point of discharge and advised to make contact if they are concerned about anything. People should not be asked to see their GP or go to the emergency department following discharge, and they should only be followed up by a new team when the person's relevant information has been handed over to the new team. Where appropriate, information provided to the person on discharge should be shared with their family, any unpaid carer(s) and providers of onward care services. Where a young carer is identified, or any professionals responsible for care planning have concerns about this, the local authority has a duty to conduct a needs assessment, where it appears that the young person may need support (see section 12).

## **Specific needs**

### **9. Palliative and end of life care needs should be anticipated and met as part of an individual's discharge journey**

Consideration should also be given to people who have palliative care needs, including those who are nearing the end of their life. Health and social care partners should work together to provide appropriate rehabilitation and reablement support from palliative and end of life specialist services and voluntary organisations. This may include support to maximise the individual's independence or meet other personal goals.

People receiving palliative or end of life care should be supported to, where possible, recover from the incident that resulted in them being admitted to the acute hospital. They should receive appropriate and compassionate support from specialist organisations post-discharge to continue living the remainder of their time with dignity and as fully as possible. People who are recognised as likely to be in their last year of life may also benefit from further support such as benefits advice and equipment. Systems should have regard to the National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care for those individuals where an appropriate clinician has decided that an individual has a primary health need arising from a rapidly deteriorating condition and the condition may be entering a terminal phase. The important role played by unpaid carers, including when they are an integral part of the care plan, and the need for carers' breaks and for carers' support is clearly set out in the NHS CHC and FNC guidance.

Health and care providers should collaborate to minimise common issues that may disrupt end of life care during the interim care period. This includes access to medication and

support, or trained professionals to administer them where necessary, and access to 24-hour nursing care and support to talk through the person's wishes and preferences. Each individual's care journey should be anticipated and mapped out, including advanced care planning, to ensure they can move through a seamless pathway to end of life care, without unnecessary disruption.

## **10. Information should be shared across relevant health and care teams and organisations across the system in a secure and timely way to support best outcomes**

One of the purposes of integrating health and social care is to ensure smoother care pathways with care joined up around a person's life, needs and wishes, including an individual's information and data being shared between relevant organisations with their consent. Relevant care information should be discussed and communicated in a timely manner to the individual and the people who will provide ongoing support, such as domiciliary care teams, GPs, unpaid carers, advocates and family members.

Health and care professionals (such as clinicians, social workers and therapists) should share appropriate information early to support a safe and timely discharge – for example about medication (including whether medication has changed since hospital admission) and immediate support needs, including transport and equipment required.

Health and care professionals should share key information about an individual's communication needs (for example if they have a learning disability or dementia), specific care preferences and details about their carer or family member. There is an opportunity to ensure that the carer is identified on the person's health and care record as well as their own health and care record. If an individual experiences substantial difficulty in communicating their needs and does not have a friend or family member to support them, an Independent Advocate must be instructed.

Local areas should work to establish information sharing protocols and mechanisms to enable data about the discharge process to be shared in a timely and effective manner to facilitate safe and timely discharges. This could include developing a shared dashboard of key activity and performance metrics, which would provide accurate information to underpin service and management decisions.



## **11. Planning and implementation of discharge should respect an individual's choices and provide them with the maximum choice and control possible from suitable and available options**

[The NHS Act 2006](#) sets out in broad terms the general duty as to patient choice in the NHS. This requires relevant bodies to “act with a view to enabling patients to make choices”.

On discharge from hospital, people who have new or additional needs should be offered choices of onward care and support to aid their recovery before any out of hospital assessment and arrangement of ongoing care and support (if needed). The choices offered should be suitable for their short-term recovery needs and available at the time of discharge.

Key to enabling choice whilst preventing delays is early and ongoing discharge planning conversations between healthcare professionals and people and their families and unpaid carers, following the principles of personalised care.

People in hospital should be supported to participate actively in making informed choices about their care, including, for people who fund their own care, the potential longer-term financial impact of different care options after discharge. These conversations should begin early in a hospital stay, and not when a person is ready to be discharged. This should also include, where appropriate, information about housing options (adaptation of the existing home and possible alternative housing, for example supported living).

Where there is disagreement between a person and their unpaid carers or family members, and the person is deemed by the appropriate professional to have capacity to make decisions relevant to their discharge, the person's right to make these decisions should be respected.

Where an individual wishes to return home and their family member or unpaid carer is unwilling or unable to provide the care needed, NHS bodies, local authorities and care providers should work together to assess and provide the appropriate health and care provision required to facilitate the individual's choice, where possible, and enable a safe discharge.

If a person's preferred care placement or package is not available once they are clinically ready for discharge, an available alternative or alternatives appropriate for their short-term recovery needs should be offered, whilst they await availability of their preferred choice. People do not have the right to remain in a hospital bed if they no longer require acute care, including to wait for their preferred option to become available.

Whilst NHS organisations should seek to offer choice to patients where such choice exists, in practice, there may be limited situations where an NHS organisation may decide to reduce the choice of services offered to people on discharge. Such situations include times of extreme operational pressures, for example, for the duration of the UK COVID-19 Level 4 National Incident. A record should be produced of the considerations of the relevant discharging body in deciding to offer that patient a reduced choice, setting out all of the material considerations for and against doing so, and the balancing exercise between the patient choice duty in the NHS Act 2006, and relevant competing duties and countervailing factors.

## **12. NHS bodies and local authorities should ensure that, where appropriate, unpaid carers and family members are involved in discharge decisions**

Family members, friends and other unpaid carers play a vital role in the care of people who are discharged from hospital. NHS bodies and local authorities should address local barriers to identifying and supporting carers throughout the hospital discharge process. This includes ensuring local authorities continue to adhere to their duties in existing legislation, for example, those outlined in the [Care Act 2014](#), and the [Children Act 1989](#).

A determination should be made as early as possible in discharge planning – or following a period of recovery – about the status and views of any carers who provide care, including that they are willing and able to do so. This will need to be age appropriate if this is a young carer under the age of 18.

In delivering sound discharge planning, NHS bodies and local authorities will need robust systems to identify carers, including young carers, early in the process.

A carer's assessment can be completed as soon as practicable after discharge, but should be undertaken before caring responsibilities begin if this is a new caring duty or if there are increased care needs. If the assessment needs to take place prior to discharge it should be organised in a timely manner so as not to delay discharge from hospital. Section 10 of the Care Act 2014 requires local authorities to carry out an assessment where it appears that an adult carer may have needs for support at that time, or in the future, and to draw up a support plan for how these needs will be met. Should carers have substantial difficulty engaging in their own assessment, they should be referred for independent advocacy support under the Care Act 2014. Young carers in particular may benefit from independent advocacy support.

Recording carers' details in electronic patient records can be one way to facilitate the identification and recognition of carers, particularly in cases where the individuals they are

caring for experience repeat admissions. There is also the opportunity to identify the carer on their own patient record.

Practitioners should note that not all individuals who are (or will be) providing ongoing care will identify as a 'carer'. If the person is nevertheless acting in the role of a 'carer', they should be regarded as one and involved in key conversations about the care needs of an individual after their discharge from hospital, or in having their own needs assessed. In other cases, the person being discharged may themselves have caring duties, such as a parent of child with a disability. Parents in this situation should be made aware of their right to an assessment of their needs (as set out in section 97 of the Children and Families Act 2014) and any additional services the local authority may need to put in place to support them in fulfilling their caring role for their child. This could include, for example, the provision of a short break or respite care to support the family.

Consideration should be given to identifying any children or young people in the household who have caring responsibilities or may have new responsibilities at the point of discharge. This may include children or young people taking on a greater caring role in relation to a disabled sibling or other child in the family, as well as providing care to a parent following discharge.

Where a young carer is identified, or any professionals responsible for care planning have concerns that the person will be discharged into the care of a person under the age of 18, the local authority should be notified of this information. Upon notification, the local authority must carry out an assessment in accordance with their responsibilities under [section 17 of the Children Act 1989](#) where it appears to the authority that the young person may need support or on request from the young carer or their parent. Any assessment should be conducted in accordance with the [Young Carers \(Needs Assessments\) Regulations 2015](#) taking into account the young carer's age, understanding and family circumstances. Local authority assessments must also consider whether it is appropriate or excessive for the young carer to provide care for the person in question, in light of the young carer's needs and wishes. The Act also specifies that the NHS has a duty to cooperate with local authorities in exercising these responsibilities.

There are instances where relationships are abusive: the individual or their carer may be abused, may abuse or be neglectful, or may have key information about abusive others. Safeguarding protocols should be followed where abuse, or risk of abuse, is identified, or staff members have concerns about abuse.

### **13. Mental capacity, advocacy and special arrangements for discharge**

Mental capacity should be assessed on a decision-specific basis. If there is a reason to believe a person may lack the mental capacity to make relevant decisions about their

discharge arrangements at the time the decisions need to be made, a capacity assessment should be carried out as part of the discharge planning process. Where the person is assessed to lack the relevant mental capacity to make a decision about discharge, a best interests decision must be made in line with the Mental Capacity Act 2005 and usual processes. No one should be discharged to somewhere assessed to be unsafe, and the decision maker must make the best interests decision.

Onward care and support options which are not suitable (for example, those not considered clinically appropriate) or available (for example, placements which are not available) at the time of hospital discharge should not be considered in either mental capacity assessments or 'best interests' decision making. Just as a person with capacity does not have a right to remain in a hospital bed if they no longer require acute care, neither is this an option for a person who lacks the mental capacity to make the discharge decision.

During discharge planning, health and care providers should continue to meet their responsibilities regarding Deprivation of Liberty Safeguards<sup>9</sup>, where appropriate. This is especially the case for, but not limited to, people with a learning disability, dementia, acquired brain injury or people currently lacking capacity to make decisions about their mental health treatment. This includes carrying out a capacity assessment before a decision about discharge is made, if there is reason to believe a person may lack the mental capacity to consent to their discharge arrangements which amount to a deprivation of liberty.

Any decision by the decision maker must be taken specifically for each person and not for groups of people. The [Deprivation of Liberty Safeguards - Code of Practice](#) outlines further information in relation to Mental Capacity.

It may be appropriate for an Independent Advocate to support an individual during the discharge planning process, and in some cases, this may be a legal requirement. Advocates are independent from the NHS and local authority and are trained to help people understand their rights and options, express their views and wishes, and help make sure their voice is heard. Advocates play a vital role for people including but not limited to people with a learning disability, dementia, acquired brain injury or people currently lacking capacity to make decisions about their mental health treatment. Referrals to Independent Advocacy services should be made as soon as discharge planning begins and ideally upon admission.

---

<sup>9</sup> [Liberty Protection Safeguards: what they are](#)

## **14. NHS bodies and local authorities should ensure people receive support that is tailored to their specific needs and circumstances**

Where there are ongoing health, housing or social care needs after discharge with different care options available, individuals (and, where relevant, their family, unpaid carers or advocates) should be empowered and supported to make the best choice for their individual circumstances.

Transfer of care hubs should incorporate appropriate safeguards for individuals who require this. For example, people who are homeless, at risk of homelessness or living in poor or unsuitable housing should be determined on admission to hospital; and individuals with a physical or learning disability and mental health needs have an increased probability of needing to use the social care system in their lifetime. Local areas should ensure that all legal responsibilities are met in relation to After-care in [section 117](#) of the Mental Health Act 1983

Health and social care professionals should follow an ongoing commitment to reducing health disparities and inequalities and consider the needs of groups that might need specialised support. This includes, but is not limited to, understanding issues relevant to people from black, Asian and minority ethnic groups, LGBTQI, faith or cultural needs, people living with disabilities, autistic people, older people, unpaid carers, people who do not speak English, and those with specific communication needs.

Any local changes to discharge arrangements should ensure that care providers are continuing to meet their responsibilities regarding Deprivation of Liberty Safeguards. This is especially the case for, but not limited to, people with a learning disability, dementia, acquired brain injury or people currently lacking capacity to make decisions about their mental health treatment.

For people where new mental health concerns have arisen, psychiatric liaison teams should be contacted by case managers in the first instance to review and assess as appropriate. A care co-ordinator or relevant mental health clinician should be involved in the discharge planning for people with a pre-existing mental health concern who are known to mental health services, to ensure their mental health needs are considered. They should ensure that the proposed onward care provider, if relevant, is fully aware of the person's support needs. For those who are being discharged from an acute hospital following an episode of self-harm, the provider should consult NICE guidelines to ensure appropriate processes are being followed<sup>10</sup>. Where individuals present with mental

---

<sup>10</sup> Current self-harm guidelines: <https://www.nice.org.uk/guidance/cg16> with new draft guidelines: <https://www.nice.org.uk/guidance/gid-ng10148/documents/draft-guideline>. New draft guidelines provide most up to date advice but are in draft form, with final guidelines expected to be published in July 2022.

distress but do not meet the criteria for secondary mental health services, a preventative mental health offer should be available.

All people who are homeless or threatened with homelessness should be determined on admission to hospital. During the hospital stay, the person should be referred by acute hospital staff to local authority homelessness or housing options teams, under the requirements of the Homelessness Reduction Act 2017, if the person consents. This duty to refer ensures services are working together effectively to prevent homelessness by ensuring peoples' housing needs are considered when they come into contact with public authorities. People who are homeless or at risk of homelessness should not be excluded from short-term post-discharge recovery and support because of their housing status. Further guidance on supporting people who are homeless when being discharged from hospital can be found in the LGA and ADASS high impact change model for managing transfers of care and the accompanying support tool.

For people living in poor or unsuitable housing the local housing authority has a duty to provide any necessary adaptations (as determined by legislation and regulations underpinning the Disabled Facilities Grant System) and assess housing needs. The local authority also has the power to implement fast track and integrated systems for such provision.

Many people admitted to acute medical units have a condition which makes them frail<sup>11</sup>. This is characterised as multiple physical, cognitive, and functional impairments resulting in longer stay in hospital, and higher rates of hospital acquired harms such as deconditioning, falls, infection, delirium, and adverse drug events. Research suggests that the average 30-day readmission rates are around 20% in this group, but many can be prevented by comprehensive geriatric assessment and discharge planning that includes a specific focus on:

- medicines reconciliation and optimisation
- patient and carer information, advice and support
- falls interventions
- provision of assistive technology to mitigate risk at home

The default pathway for people with frailty should be Home First, with intermediate care at home to regain functional ability after discharge. However, some people with more severe frailty may require a period of step-down bed-based care to support them to regain

---

<sup>11</sup> Conroy S, Dowsing T (2013) The ability of frailty to predict outcomes in older people attending an acute medical unit. *Acute Med* 12(2):74–6

confidence and independence in a homelike environment. For those individuals, care should adopt a reablement approach and be supported by the community intermediate care team in order to maximise recovery and delay progression to long term residential care.

### **Terms used in this guidance**

Carers: all unpaid family members, friends and others who are providing care to the person being discharged. This includes (but is not limited to) adult carers, young carers, young adult carers and parent carers.

Local areas: collective term for NHS bodies (including commissioning bodies, NHS Trusts and NHS Foundation Trusts) and local authorities exercising functions in England.

### **Key documents that have been drawn upon include:**

- This guidance should be read alongside the [2015 NICE guideline on transition between inpatient hospital settings and community or care home settings for adults with social care needs](#)
- For further details on Discharge to Assess please see: [NHS Quick Guide: Discharge to Assess](#)
- CQC Guidance on [Trusted Assessors Requirements when people are discharged from hospital to adult social care services under 'Trusted Assessor' schemes](#)
- [BASW England Health and Care Bill briefing](#)
- [BASW England policy response: Health and Social Care Bill](#)
- [ADASS snap survey findings](#)
- Barnardo's report: [Still Hidden Still Ignored Barnardo's young carers report](#)
- Discharge to assess also forms part of [the LGA and ADASS high impact change model for managing transfers of care](#)

- [Managing transfers of care – A High Impact Change Model: Changes 1-9](#) | Local Government Association
- [Guidance to local authority commissioners is](#) available from ADASS, the LGA and the Care Provider Alliance (CPA)
- Newton Europe publications: [Why not home, Why not today?](#) and [People first: manage what matters](#)
- [Community health and care discharge and crisis care model: an investment in reablement](#)
- The LGA and ADASS have produced 2 ‘tops tips’ guides: [Top tips guidance on implementing a home first approach to discharge from hospital](#) and [Top tips guidance on implementing a collaborative commissioning approach to home first](#)

For queries relating to this guidance, please contact [discharge@dhsc.gov.uk](mailto:discharge@dhsc.gov.uk).



## **Annex A - Contributing organisations**

As well as local and national government and NHS departments, representatives from the following organisations have contributed to the development of this guidance:

- ADASS
- Age UK
- Barnardo's
- The British Association of Social Workers
- British Geriatrics Society
- The British Red Cross
- Care England
- Care & Repair England
- Carers UK
- The Carers Trust
- The Care Quality Commission
- Doris Jones Ltd.
- Healthwatch England
- Homecare Association
- Local Government Association
- Prof. John Bolton
- The National Care Forum
- NHS Providers
- The Patients Association
- Principal Social Workers Network
- The Royal College of Occupational Therapists

## **Annex B – Specific responsibilities related to hospital discharge processes**

The following lists existing duties and best practice for NHS bodies, local authorities and care providers to follow when planning and delivering hospital discharge services.

### **Commissioners of health and care services should:**

- Ensure that, where appropriate, onward health services and care packages for those discharged (including commissioning of care home beds) are jointly commissioned; and the local authority should be the lead commissioner unless otherwise agreed between the NHS body and the local authority. There should be clear agreement around who is responsible for paying for the package of care, including the use of pooled funding arrangements where appropriate in a way that is affordable within existing budgets available to NHS commissioners and local authorities
- provide adequate health and care discharge services, operating 7 days a week
- work in partnership to plan and commission sufficient provision to meet the needs of the population
- work in partnership to co-ordinate local financial flows for post-discharge care and support, including monitoring all local spend and co-ordinating local funding arrangements
- continue to build on recent learning and commissioning arrangements for community palliative care services, optimising the best use of all available financial resources including those currently allotted to CHC fast track. Enabling community palliative care services to provide palliative and end-of-life care for those people transferring to, or already in, the community requiring care and support within their own home or a hospice
- continue to promote the use and development of effective tracking tools for care homes, hospices and community rehabilitation bed providers. They should ensure that the operational potential of domiciliary and residential capacity trackers is realised, through their use in health and care system wide discharge planning, and that the effectiveness of reablement and rehabilitation is monitored
- work with system partners to ensure appropriate data collection and that its use supports the best outcomes for individuals
- give clear information to providers on which contract will be used, for example, NHS commissioning bodies must use the [NHS Standard Contract](#)

## **Local authorities should:**

- as outlined in the Care Act, take the lead on local care market shaping, including contracting responsibilities (for example, expanding the capacity in domiciliary care and reablement services in the local area, and ensuring that long term strategic provisions are developed, with surge capacity for winter pressure periods)
- work with CQC and other regulators to ensure safeguarding and quality of care, advising NHS colleagues where action is needed to make provision safe or alternatives are needed
- engage local housing authority services to provide housing support and advice for persons requiring housing assistance on discharge from hospital
- agree a single lead local authority or point of contact arrangement for each hospital system, ensuring each acute trust and single co-ordinator has a single point to approach when co-ordinating the discharge of all people, regardless of where that person lives
- work with partners to co-ordinate activity with local and national voluntary sector organisations to provide services and support to people requiring support around discharge from hospital and subsequent recovery
- In respect of young carers, local authorities must carry out an assessment upon the request or appearance of need, and this assessment must consider whether it is appropriate or excessive for the young carer to provide care

## **Local authority adult social care teams should:**

- make provision for Care Act assessments of need, financial assessments and longer-term care planning to take place following discharge
- ensure expert social work professionals can contribute to hospital based multidisciplinary discussions and decision making occurring before discharge
- ensure social care expertise is a central part of the process to determine the long-term care needs of and with people following a period of recovery and rehabilitation and that they are fully aware of their options and the implications of each choice
- continue to conduct safeguarding activities in a hospital setting if necessary
- provide capacity to review care provision and change if necessary, at an appropriate point, in line with good practice and legal responsibilities

- assess whether a carer has needs for support (or is likely to do so in the future) and, if the carer does, what those needs are (or are likely to be in the future)
- identify an executive lead for the leadership and delivery of hospital discharge processes
- provide social care capacity to work alongside local community health services via the transfer of care hub
- support real time communication between the hospital and the single coordinator, not just by email
- work with NHS bodies to ensure appropriate data collection and that its use supports the best outcomes for individuals

### **Adult social care and care providers should:**

- work in collaboration to plan and monitor local capacity to ensure there is appropriate social care support in place to support effective hospital discharges
- where possible, support 7-day working for community social care teams (commissioned by local authorities) and other care provision
- deploy adult social care staff flexibly to support best outcomes for people. This can include support to avoid any immediate bottlenecks in arranging step down care and support in the community, and at the same time focus on maintaining and building capacity in local systems
- provide feedback on hospital discharge commissioning and contracting arrangements and seek improvements, where relevant

## **Acute Health Providers**

### **Hospital discharge teams should:**

- arrange dedicated staff to support and facilitate hospital discharge. This will include:
  - making arrangements to ensure there is transport for people to return home from hospital. This should be via family/carers where appropriate/suitable, voluntary sector, or taxi and, only as a last resort, non-emergency patient transport services (NEPTS)
  - local voluntary sector and volunteering groups helping to ensure people are supported (where needed) actively for the first 48 hours after discharge

- ensuring people have full information about the next steps of their care and be provided with a discharge summary which includes any changes to pre admission medication regime
- ensuring 'settle in' support is provided where needed
- in conjunction with local care home providers, develop trusted assessment arrangements to facilitate the prompt return of their own residents after a hospital stay
- ensure that required medication and essential equipment are provided at the point of discharge, and that information about this is provided to onward care providers, the individual and, where appropriate, their family and unpaid carers

**Hospital clinical and managerial leadership teams should:**

- create safe and comfortable discharge spaces for people to be transferred to from all ward areas
- maintain timely and high-quality transfer of information to primary care and all other relevant health and care professionals on all people discharged
- maintain provision for senior clinical staff to be available to support ward and discharge staff with appropriate risk-management and clinical advice arrangements
- engage with commissioning bodies and regional colleagues to support clinical and medical leaders in implementing discharge processes and culture
- closely monitor hospital discharge performance data to ensure discharge arrangements are operating effectively and safely across the system, including over seven days, and that a high proportion of people on the discharge list achieve a same-day discharge to the most suitable destination for their needs
- ensure that, as part of daily ward rounds, timely and accurate data is collected and submitted to the Acute Daily Discharge Situation Report. It is important this is a clinically driven data collection
- ensure a live list is available for all agencies to work from and include those suitable for discharge, the number and percentage of people on the list who have left the hospital, and reason of delay for those unable to be discharged in a timely way

**Community health service providers should work closely with other system partners to facilitate timely discharge of people. As part of this they should:**

- have an easily accessible contact within the transfer of care hub who will always accept referrals from staff in the hospital and source the care requested, in conjunction with local authorities
- monitor the effectiveness of reablement and rehabilitation, with local authority partners as appropriate
- use multi-disciplinary teams on the day a person goes home from hospital, to assess and arrange packages of support
- ensure provision of equipment to support discharge
- ensure individuals are closely tracked and followed up regularly to ensure their care support is appropriate
- take part in assessing the long-term needs of an individual at the end of the period of recovery
- maintain a focus on supporting timely onward transition of care for people receiving care in community beds (rehab and short-term care) and support them with reablement and rehabilitation packages in home settings following their discharge from a 24-hour bedded unit
- collect and submit data on the delivery of services to the Community Services Data Set (CSDS) and bed rehabilitation weekly SITREP
- use the Capacity Tracker tool for identifying the bed capacity in community rehabilitation bed providers
- for people identified as being in the last days or weeks of their life, the transfer of care hub will be responsible for co-ordinating liaison with primary care, community services and community palliative care services to co-ordinate and facilitate rapid discharge to the person's home or a hospice

Community Palliative Care teams will continue to co-ordinate and facilitate prompt discharge to home or hospice. End-of-life care, including palliative care, and pre- and post-bereavement support, must continue to be personalised and planned in a holistic way involving the person themselves and their families, social care, community nursing, general practice, occupational therapy, and others.

## **Annex C – Pathways for the Discharge to Assess Model**

Adapted from John Bolton model for persons aged 65 and over, and when used across all 18+ age groups, it is expected that a greater percentage than detailed will be allocated to pathways 0 and 1:

### **Pathway 0**

Likely to be minimum of 50% of people discharged:

- simple discharge home
- no new or additional support is required to get the person home or such support constitutes only:
  - informal input from support agencies
  - a continuation of an existing health or social care support package that remained active while the person was in hospital

### **Pathway 1**

Likely to be minimum of 45% of people discharged: able to return home with new, additional or a restarted package of support from health and/or social care. This includes people requiring intensive support or 24-hour care at home.

Every effort should be made to follow Home First principles, allowing people to recover, reable, rehabilitate or die in their own home.

### **Pathway 2**

Likely to be maximum of 4% of people discharged: recovery, rehabilitation, assessment, care planning or short-term intensive support in a 24-hour bed-based setting, before returning home

### **Pathway 3**

For people who require bed-based 24-hour care: includes people discharged to a care home for the first time (likely to be a maximum of 1% of people discharged) plus existing care home residents returning to their care setting (for national data monitoring purposes, returning care home residents will count towards the 50% figure for Pathway 0).

Those discharged to a care home for the first time will have such complex needs that they are likely to require 24-hour bedded care on an ongoing basis following an assessment of their long-term care needs.



## **Annex D - Criteria to reside – maintaining good decision making in acute settings**

Every person on every general ward should be reviewed on a twice daily ward round to determine the following. If the answer to each question is 'no', active consideration for discharge to a less acute setting must be made:

- Requiring ITU or HDU care?
- Requiring oxygen therapy/NIV?
- Requiring intravenous fluids?
- NEWS2 > 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/pelvic surgery with 72 hours?
- Within 24 hours of an invasive procedure? (with attendant risk of acute life- threatening deterioration)

Clinical exceptions will occur but must be warranted and justified. Recording the rationale will assist meaningful, time efficient review.

### **Review and challenge questions for the clinical team**

Is the person medically optimised? Do not use 'medically fit' or 'back to baseline'.

What management can be continued as ambulatory, for example heart failure treatment?

What management can be continued outside the hospital with community/district nurses? For example, IV antibiotics?

Persons with low NEWS (0-4) scores – can they be discharged with suitable follow up?

- if not scoring 3 on any one parameter – for example, pulse rate greater than 130
- if their oxygen needs can be met at home
- stable and not needing frequent observations every 4 hours or less
- not needing any medical/nursing care after 8pm:
  - people waiting for results – can they come back, or can they be phoned through?
  - repeat bloods – can they be done after discharge in an alternative setting?
  - people waiting for investigations – can they go home and come back as outpatients with the same waiting as inpatients?

### **Criteria-led discharge**

Can a nurse or allied health care professional discharge without a further review if criteria are well written out?

Can a junior doctor discharge without a further review if criteria are clearly documented?

How can we contact the consultant directly if criteria are only slightly out of range and require clarification?

© Crown copyright 2022

[www.gov.uk/dhsc](http://www.gov.uk/dhsc)

This publication is licensed under the terms of the Open Government Licence v3.0 except where otherwise stated. To view this licence, visit [nationalarchives.gov.uk/doc/open-government-licence/version/3](http://nationalarchives.gov.uk/doc/open-government-licence/version/3)

Where we have identified any third party copyright information you will need to obtain permission from the copyright holders concerned.

