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Hospital Discharge and Community Support: Staff Action Card

How your role helps to implement best practice outlined in the Hospital discharge and community support guidance.

Key messages for all staff

- Early discharge planning is required from admission (for emergency admissions) and prior to admission (for elective admissions). This enables people and their family members/carers to ask questions and receive timely information to support them in discussions and decisions about their discharge. For those likely to require health and/or social care and support post-discharge, early discharge planning must involve the person and any unpaid carers (including young carers), where appropriate, as per the duty in the Health and Care Act 2022.
- All people who no longer meet the clinical criteria to reside for inpatient care in acute hospitals or who no longer need inpatient care in community hospitals should be discharged **as soon as it is possible and safe**. Local areas should adopt discharge processes that best meet the needs of the local population. This could include the Discharge to Assess model and Home First approach.
- Every local health and social care system based around an acute hospital site should have a Single Coordinator, reporting to an Executive Lead, to lead and drive the discharge agenda across the system.
- Where Discharge to Assess is implemented, discharge home should be the default pathway (Pathways 0 & 1). People may also be transferred to non-acute settings (Pathways 2 & 3). A Case Manager may be assigned to all those requiring health and/or social care and support post-discharge to aid their recovery prior to any assessments of ongoing needs (Pathways 1, 2 & 3). A Transfer of Care Hub based around an acute hospital site should link services to coordinate care and support to aid discharge, recovery and admission avoidance.
- People should be discharged as soon as it is possible and safe following a medical decision to discharge. People on all pathways should be discharged as early in the day as possible, ideally before 5pm, as agreed with people and their family members/carers and any providers of onward care and support.
- Staff training is available via the Home First Act Now eLearning Programme. For the latest information on COVID-19 requirements for people discharged to care homes, please see Infection prevention and control in adult social care settings and Infection prevention and control in adult social care: COVID-19 supplement.

ACUTE THERAPY TEAMS

A significant part of your work should now be in non-acute settings (mainly in people's homes).

What should I do differently?

- Where Discharge to Assess is implemented, limited assessments for discharge should be undertaken on a ward or other acute hospital setting / designated therapy assessment area.
- If following the Discharge to Assess model, prompt assessments of short-term recovery care and support needs (and after a period of recovery, assessments of long-term or ongoing care and support needs) should take place after discharge in non-acute settings (mainly in people's homes).
- Work alongside adult social care colleagues to agree a recovery and support plan with the person and their family members/carers, including reablement and equipment.
- Assessments should be trusted assessments and should therefore be accepted by any receiving care providers (a universal document to be used across acute and community services should be agreed).

When and where should I do my work?

- You should work much more fluidly between community settings, people's homes and within the acute trust, depending on demand and capacity and learning from the pandemic.
- Cover should continue to be required seven days a week so you may find your hours of work are adjusted.

Case Manager role (where appropriate)

- It is best practice for the Transfer of Care Hub to direct (for each person) who should be the Case Manager to aid and monitor a person's discharge and recovery.
- Acute therapists may particularly, but not exclusively, undertake the Case Manager role for people who:
    - Have rehabilitation needs following illness or trauma.
    - Require help to manage and self-manage long-term conditions.
    - Have progressive illnesses where interventions can help them to maintain their independence for as long as possible.