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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.

BEDDED REHABILITATION (THERAPIES)

You will need to decrease the overall length of stay to create more capacity and allow more people to benefit from rehabilitation. Your work may now have a greater focus on community outreach.

How should I work differently with colleagues?

- There should be a Case Manager assigned to each person and acting on behalf of the local health and social care system who should liaise directly with your unit to facilitate the discharge.
- There should be an increase in the availability and timeliness of relevant services within the community to help people regain autonomy at home.

What should I do differently?

- Start a daily clinical review (10-20 mins) of the plan for every person focussing on the key questions: 'Why not home? What needs to be different so they can go home? Why not today?'. Assess people for discharge against the clinical criteria to reside for inpatient care in community beds.
- Use 'Discharge to Assess' pathways as a best practice model for discharge routes from community rehabilitation beds, where such pathways are in place locally.
- Act as a trusted assessor for onward referrals. You should not expect to have to re-do assessments, or to use lengthy referral forms.
- You may use technology for outreach and follow-up to reduce travel time.
- All equipment and care needs should be assessed within the person's home using the locally agreed routes.
- You should update the national Capacity Tracker with your bed status to help the management of overall NHS bed capacity.

When and where should I do my work?

- You may be required to provide outreach support to a person in the community. The Transfer of Care Hub should direct the process.
- Cover will continue to be required seven days a week so you may find your hours of work are adjusted.