HM Government

NHS

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.

ADULT SOCIAL CARE TEAMS

A significant part of your work should now be in non-acute settings, working alongside therapists to support people, mainly in their own 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. Acute-based safeguarding investigations should continue.
- Where practical, agree a single lead local authority contact who should work with or as part of the Transfer of Care Hub.
- Work alongside acute therapists to assess people for short-term care and support needs to aid recovery at the request of the Transfer of Care Hub and agree a recovery and support plan with the person and their family members/carers, including reablement and equipment.
- Coordinate with housing and local and national voluntary sector organisations to provide services and support to people on discharge. Utilise assistive technologies (telehealth and telecare) where helpful. The use of equipment may help to reduce double-handed care to single-handed care.
- Work with unpaid carers, providing them with support and undertaking a carer's assessment where needed. Children who are young carers should be referred for young carers needs assessments or young carers support services as appropriate.
- Where Discharge to Assess is implemented, conduct Care Act (2014) assessments of long-term or ongoing social care needs and funding eligibility after discharge, in non-acute settings, and at the end of the recovery period, if required.

When and where should I do my work?

- An Adult Social Care presence in the acute trust should be reduced but ASC staff will still need to work closely with acute colleagues and some presence will be required. An ASC presence in community hospitals should be agreed to support recovery as part of MDT working. ASC staff input into Transfer of Care Hubs should be over 7 days.

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.
- Social workers may particularly, but not exclusively, undertake the Case Manager role for people who:
  - Have complex capacity issues.
  - Have identified safeguarding risks.