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.

MANAGERS OF THE DISCHARGE TEAM

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

How should I work differently with colleagues?

- Where Discharge to Assess is implemented, you may continue to liaise with wards in relation to people on Pathway 0 (those discharged home without formal care and support). In some acute hospitals another team may be responsible for discharge of those on Pathway 0.
- It is advised that you work as part of the Transfer of Care Hub in relation to people on Pathways 1, 2 & 3 (those requiring health and/or social care and support following discharge).
- Homeless people and people at risk of homelessness should be referred to the local authority. Mental health clinicians should be consulted for people with mental health needs

What should I do differently?

- Where Discharge to Assess is implemented, arrange dedicated staff to manage Pathway 0 discharges, if responsible.
- If following the Discharge to Assess model, ensure Case Managers, working with the Transfer of Care Hub, coordinate an initial safety and welfare check on the day of discharge for people on Pathways 1, 2 & 3; and ensure these people are assessed promptly for short-term care and support needs to aid their recovery in their discharge destination (usually their own home / usual place of residence).
- It is advised that you ensure there is adequate capacity amongst Case Managers assigned to people on Pathways 1, 2 & 3 to enable them to monitor progress against recovery and support plans and ensure assessments of any long-term or ongoing care needs (if required) are undertaken as soon as it is possible to get an accurate picture.
- You must ensure that any unpaid carers (including young carers) are involved in early discharge planning conversations, where appropriate, as per the duty set out in the Health and Care Act 2022 (applicable from July 2022).

When and where should I do my work?

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