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.

MEMBERS OF THE DISCHARGE TEAM

Where Discharge to Assess is implemented, you should continue discharging people on Pathway 0 (straight home without formal care and support) if responsible. A significant proportion of your work should be focused on discharging people on Pathways 1, 2 & 3 (those requiring health and/or social care and support following discharge).

How should I work differently with colleagues?

- Where Discharge to Assess is implemented, you should supplement 'Discharge to Assess' capacity, working as part of and directed by the Transfer of Care Hub, and supported by your line manager.
- 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?

- Responsibilities could include (this is not an exhaustive list and will depend on local arrangements and individual skillsets):
  - Accompanying people to the discharge lounge and, on discharge, accompanying people home or to a non-acute setting.
  - Acting as a trusted assessor for care homes and community bed settings.
  - Supporting people to manage their own recovery by identifying and activating their knowledge, skills and confidence.
  - Supporting the effective flow of people.

When and where should I do my work?

- You are likely to need to work more flexibly to support the new requirements. Cover will continue to be required seven days a week.

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. Members of the Discharge Team may undertake the Case Manager role if appropriate.