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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.

SINGLE COORDINATOR

- **Every local health and social care system based around an acute hospital site should have a Single Coordinator to lead and drive the discharge agenda across the system**
- **The Single Coordinator should report to a named Executive Lead**
- **The Single Coordinator may be employed by any organisation in the system and can be from any professional background**

In performing this system leadership role, you should develop a shared system view of discharge, hold all parts of the system to account and drive system actions to address shared challenges. Your remit may also encompass admission avoidance if this makes sense locally.

Critical success factors

- **A common purpose and shared vision – e.g. a clear and consistent focus on 'Discharge to Assess' and 'Home First', where implemented locally – will help to generate commitment from all partners.**
  - You should work closely at operational level to ensure safe and timely discharge on the appropriate pathway for all individuals.
  - You will need to work with and for the whole system and not be seen to belong to or represent one area.
  - You should quickly develop a working understanding of how a therapy-led approach can support timely and effective discharges.
- **Enough decision-making authority – this will not only shape how quickly change can be made but also its impact.**
  - You should identify and remove blockages and, where necessary, change processes across the whole system.
  - You should use your personal attributes and position as a senior member of staff to bring about change
- **Sphere of control – this will determine how your role can bring about change, whether through direct decision-making or by influencing.**
  - You should direct discharge support services in the acute and community
  - You should use conflict management skills as you make changes that best serve people rather than systems.
  - You should work at a micro and macro level and intervene in individual cases and change the overall process where required.
- **Working with partners – working with partners earlier rather than later will make for more credible implementation**.
  - You should deploy codesign and codelivery with all stakeholders.
  - Where implemented, you should promote 'the vision' of a successful D2A model and 'Home First' approach across the whole system.