HM Government

NHS

Hospital Discharge and Community Support: Staff Action Card

A function to help 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.

TRANSFER OF CARE HUB

- **Every local health and social care system based around an acute hospital site should have a Transfer of Care Hub to link a wide-range of health and social care and wider services**
- **The Hub should play a key coordinating role to aid discharge and also admission avoidance if this makes sense locally due to overlapping services and staff**
- **The Hub should operate seven days a week, ensuring discharges are timely and Urgent Community Response standards are met**

The Transfer of Care Hub is the local health and social care system-level coordinating centre (fully or partially co-located with acute settings where suitable) linking all relevant services across sectors to aid discharge and recovery and admission avoidance.

What is the Transfer of Care Hub?

- System-level place whereby (physically and / or virtually) all relevant services (e.g. acute, community, primary care, social care, housing and voluntary) are linked in order to coordinate care and support for people who need it – during and following discharge and to prevent acute hospital admissions.
- Responsible for developing timely and person-centred 'step-down' or 'step-up' plans for people based on the principle of 'no place like home'.

Discharge and recovery role

- Supports safe discharges through close working with the acute wards, quality assurance of information and practical support, including early identification of people who may become ready for discharge.
- Where Discharge to Assess is implemented, decides which pathway each person should be placed on (1, 2 or 3) based on the description of the person received from acute wards; also assigns a Case Manager to each person.
- Works with the assigned Case Manager to ensure an initial safety and welfare check takes place on the day of discharge.
- Coordinates and arranges the recovery care and support needed on discharge, liaising with family members/carers and relevant care providers, and ensures the staff and infrastructure are available to meet the person's recovery needs.
- Provides information about when and how assessments of long-term needs should take place and financial implications based on a person's identified status at assessment stage (e.g. NHS CHC/FNC-, local authority-, or self-funded).

Admission avoidance role (if applicable)

- Decides which pathway each person should be placed on – e.g. 2-Hour Urgent Community Response or other pathway – based on the information provided during the referral process.