



Hospital Discharge Service: Policy and Operating Model

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1. Summary

- 1.1. This document sets out the Hospital Discharge Service operating model for all NHS trusts¹, community interest companies, and private care providers of NHS-commissioned acute, community beds, community health services and social care staff in England. It replaces the Hospital Discharge Service Requirements.
- 1.2. The Government has provided funding, via the NHS, to help cover the cost of post-discharge recovery and support services, rehabilitation and reablement care for up to six weeks following discharge from hospital.
- 1.3. The discharge to assess model will be fully implemented across England.
- 1.4. From 1 September 2020, the Government has decided that social care needs assessments and NHS Continuing Healthcare (CHC) assessments of eligibility will recommence.
- 1.5. We acknowledge and thank the Local Government Association, Association of Directors of Adult Social Services and the Academy of Medical Royal Colleges for their involvement and support in developing this guidance.

¹Mental Health inpatient services are not within scope for this guidance. Parallel guidance on managing demand and capacity across mental health, learning disability and autism services has been developed and should be consulted.

2. Introduction

- 2.1 Health and social care systems are expected to build upon the hospital discharge service developed during the COVID-19 response, incorporate learning from this phase, and ensure discharge to assess processes are fully embedded for all people aged 18+.
- 2.2 To support full implementation of discharge, a set of [discharge guidance action cards](#) has been developed to summarise responsibilities for key roles within the hospital discharge process.
- 2.3 Based on the criteria to reside in hospital as developed with the Academy of Medical Royal Colleges ([see Annex A](#)), acute hospitals must discharge all persons who no longer meet these criteria as soon as they are clinically safe to do so. Daily morning ward rounds to review every person and make decisions, informed by the criteria to reside, are the foundation for avoiding delay and improving outcomes for individuals. Transfer from the ward to a designated discharge area should happen promptly; for persons on Pathway 0 this should be within one hour of that decision being made, and the same day for people on all other pathways. Discharge from the discharge area should happen as soon after that as is possible and safe which will often be within two hours, or on the same day.
- 2.4 Acute and community hospitals must integrate the daily reviews into their electronic patient information systems. This will ensure a live list is available for all agencies to work from and include those suitable for discharge, the number and percentage of people on the list who have left the hospital, and reason of delay for those unable to be discharged in a timely way. This data will also form part of national data performance reporting arrangements.
- 2.5 These reporting arrangements build on situation reporting processes implemented during the COVID-19 response in March 2020, this included the suspension of Delayed Transfer of Care (DTC) data collection and submissions. NHS providers should no longer record or report DTC data, which has been superseded by the data collections outlined in this document (see [section 11](#)).
- 2.6 The Government has agreed to provide additional funding, via the NHS, alongside existing use of local authority and Clinical Commissioning Group (CCG) budgets to help cover the cost of post-discharge recovery and support services in addition to what was provided prior to admission, for up to a maximum of six weeks following discharge from hospital or any “Pathway 2” facility. This funding will apply to all those needing support for the first time.

- 2.7 The recovery and support provided post-discharge (including rehabilitation and reablement services) aims to help people return to the quality of life they had prior to their most recent admission. For some people this may require support for these additional needs for the maximum period of six weeks, although for the majority it will be suitable for them to return to usual packages of care (if applicable) in less time. The funding can also be used for urgent community response provided within 2 hours to prevent an acute admission.
- 2.8 Social care needs assessments and NHS Continuing Healthcare (NHS CHC) assessments of eligibility should be made in a community setting and not take place during the acute hospital inpatient stay. From 1 September 2020, the Government has decided these assessments will recommence where they have been suspended during the COVID-19 response. Further [guidance specific to NHS CHC arrangements on discharge from hospital can be found here](#).
- 2.9 It is essential that, under the new arrangements, there is clarity about which CCG is responsible for assessing each person's needs and paying the relevant organisation for any healthcare services provided to the individual. NHS England is publishing updated [Who Pays? rules](#) to provide this clarity.
- 2.10 The Government is making additional funding available to support the health and social care systems implement this approach during the financial year 2020/21. Local authorities and NHS bodies need to continue to work together to put this approach into practice in line with the [Community Health and care discharge and crisis care model: an investment in reablement](#)

3. Discharge to Assess arrangements

- 3.1 The [discharge to assess pathways model](#), is based on four clear pathways for discharging people, as shown below:

Discharge to Assess model – pathways²:

- Pathway 0: 50% of people – simple discharge, no formal input from health or social care needed once home.
- Pathway 1: 45% of people – support to recover at home; able to return home with support from health and/or social care.
- Pathway 2: 4% of people – rehabilitation or short-term care in a 24-hour bed-based setting.
- Pathway 3: 1% of people – require ongoing 24-hour nursing care, often in a bedded setting. Long-term care is likely to be required for these individuals.

- 3.2 Acute hospitals will continue to be the responsible organisation for discharge of all persons on pathway 0, ensuring that the 50% of people who can leave the hospital and only need minimal support, do so on time and safely.
- 3.3 People should only be discharged on this pathway if they are considered to be well enough for self-care upon discharge.
- 3.4 Upon discharge, people should receive information about who they can contact if their condition changes, ranging from re-admission to voluntary sector help for day-to-day tasks.
- 3.5 This pathway may include a limited number of arranged follow ups (for example, the removal of stitches in a clinic setting or at home). However, this pathway should not include ongoing care.
- 3.6 Voluntary sector services can also be used to support discharge and prevent further admissions to hospital.
- 3.7 Health and social care systems should have an identified executive lead to provide strategic oversight of the discharge to assess process ensuring that there are no delays to discharge and that a “home first” approach is being adopted. They should

² Adapted from John Bolton model for persons aged 65+. When used across all 18+ age groups it is expected that a greater % than detailed here will be allocated to pathways 0 and 1, and a fewer than detailed % to pathways 2 and 3.

be supported by a single coordinator who should be appointed on behalf of all system partners to secure timely discharge on the appropriate pathway. They can be employed by any partner in the system to lead the implementation and delivery of the discharge to assess model in the acute hospitals in their area. This lead role should be undertaken by the most appropriate person for the position, regardless of which organisation they are employed by. Their primary function will be the oversight of coordination of the discharge arrangements for all people from community and acute bedded units on pathways 1, 2 and 3; escalating any relevant issues to the Executive Lead. The model should operate 8am-8pm, 7 days a week.

- 3.8 Case managers will ensure all people (irrespective of their address) are discharged safely on time (from all NHS community and acute beds) and that they (or their representative or advocate if they lack capacity), have full information and advice about what is happening. This includes how their needs will be assessed, provision of follow up support as needed and if any charges will be applied to their care and support.
- 3.9 Discharge to assess pathways 1-3 require NHS organisations to work closely with adult social care and housing colleagues, the care sector and the voluntary sector. To ensure that resources are used effectively across the system, acute trusts should ensure that their staff work closely with community health services and local authorities on pathways 1-3.
- 3.10 Information essential to the continued delivery of care and support must be communicated and transferred to the relevant health and care partners on discharge. This must include, where relevant, the outcome of the last COVID-19 test.
- 3.11 Commissioners will need to determine which health and care services can best meet the needs of individuals, considering the range of health and care providers offering services in their locality.
- 3.12 Whilst most people will be discharged to their homes, a very small proportion will need and benefit from short or long term residential, nursing home or hospice care as part of pathways 2 and 3. No-one should be discharged from hospital directly to a care home without the involvement of the local authority.
- 3.13 DHSC/PHE policy is that people being discharged from hospital to care homes are tested for COVID-19 in a timely manner ahead of being discharged (as set out in the [Coronavirus: adult social care action plan](#)), regardless of whether they were residents of the care home previously or not. Where a test result is still awaited, the person will be discharged if the care home states that it is able to safely isolate the patient as outlined in [Admission and Care of Residents in a Care Home](#) guidance. If this is not possible then alternative accommodation and care for the remainder of the

required isolation period needs to be provided by the local authority, funded by the discharge funding.

- 3.14 There needs to be clear accountability and escalation mechanisms at each stage of the discharge to assess process in each locality ([Annex C](#)). Figure 1 on the following page describes the discharge to assess process that should be undertaken in acute and community hospitals, and once the person is home. Health and care systems should ensure effective information sharing, and full and carefully documented assessments of need, to ensure care providers can deliver the care and support people require.

Figure 1: Discharge to assess process (see below for plain text version)

Aim: to support people to maximise their independence and remain in their own home

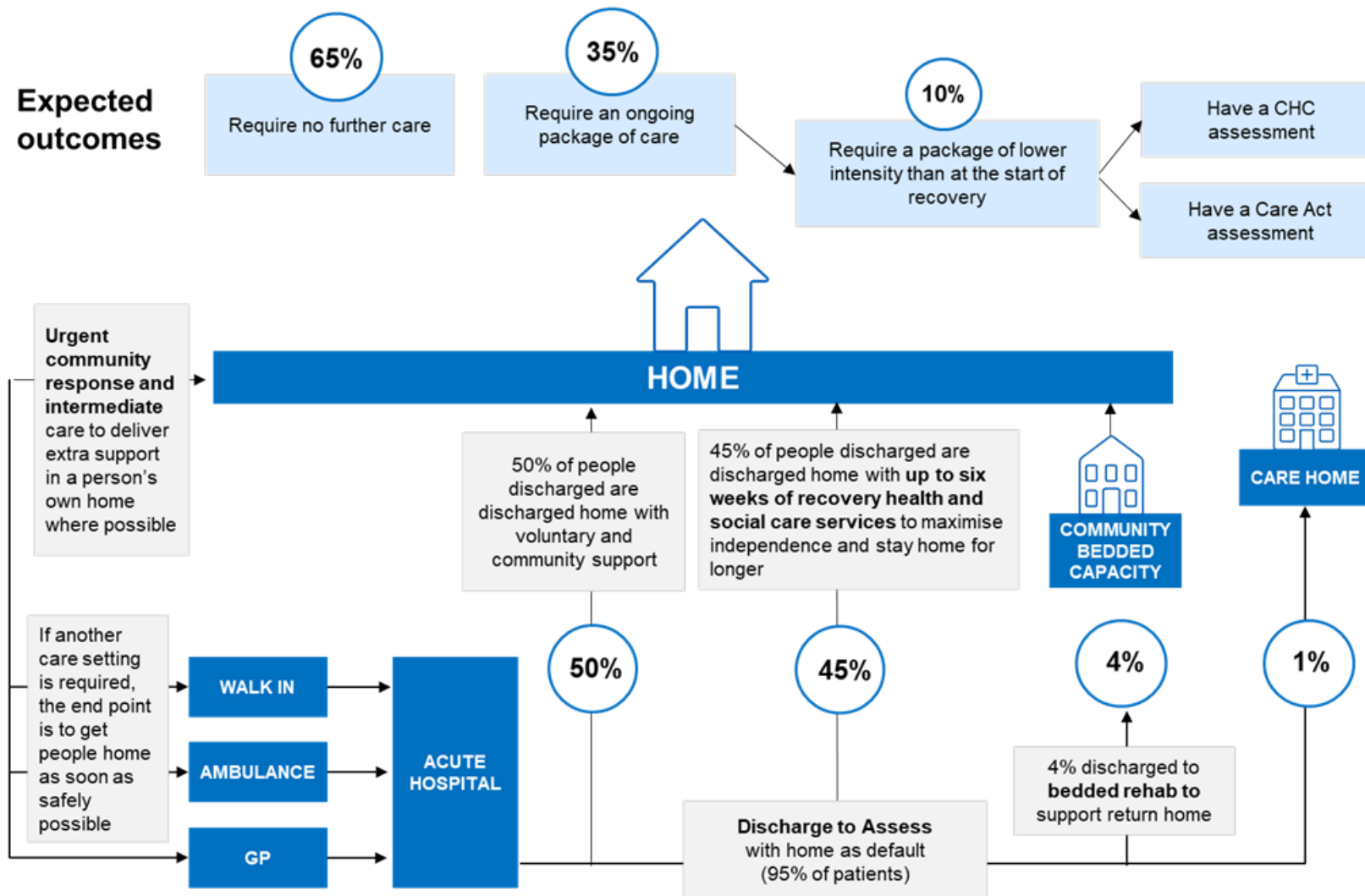


Figure 1: Discharge to assess process (plain text)

Aim: to support people to maximise their independence and remain in their own home.

Expected outcomes on discharge from hospital:

- 65% of people will require **no further care**.
- 35% of people will require an **ongoing package of care**.
 - o Of those 35% of people who receive ongoing care, it is expected that 10% will require a package of lower intensity than at the start of recovery, and will have either an NHS CHC, or Care Act assessment.

Urgent community response and intermediate care to deliver **extra support** in a person's own home where possible.

If another care setting is required, the end point is to get people home as soon and as safely as possible.

- For those admitted to an acute hospital, 95% are expected to be discharged home as default. The discharge to assess model sets out 4 pathways:
 - o 50% of people are expected to be discharged home with voluntary and community support.
 - o 45% of people are expected to be discharged home with up to six weeks recovery support from health and social care services, to maximise their independence and stay home for longer.
 - o 4% of people are expected to be discharged to bedded rehabilitation settings to support their return home.
 - o 1% of people are expected to be discharged into long-term care settings, such as a care home.

There are three stages to the discharge to assess model:

Stages	Description of stage
Stage one <u>Review each individual daily and identify people for discharge to leave that day</u>	➤ Begin discharge planning from the point of hospital admission, including the identification of immediate needs of the individual at home following discharge. ➤ Undertake daily clinically-led reviews of all people at a morning ward round. Any person not meeting the clinical criteria to reside (see Annex A) will be deemed suitable for discharge. ➤ Information about the home circumstances for people should have been collected at the point of admission. If further home assessment is required this should be undertaken in good time, coordinated between health and social care and should include equipment and reablement support. Trusted assessment arrangements should be used. ➤ All people who are suitable for discharge will be added to the discharge list. ➤ Discharge home should be the default pathway. ➤ At least twice daily review of all people in acute beds to agree who no longer needs to be in hospital and can be discharged. ➤ For people being discharged into a care home, supported housing or other temporary accommodation, a COVID-19 test must be carried out prior to admission. ➤ Senior clinical staff should be available to support staff with appropriate risk-management and clinical advice.
Stage two <u>The details of how to discharge people</u>	➤ On decision of discharge, the person and their family or carer, and any formal supported housing workers should be informed and receive the relevant leaflet (see Annex B).

	➤ Community health, social care and acute staff need to work in full synchronisation (include housing professionals where necessary) to ensure people are discharged in a safe and timely manner. ➤ For people who are going straight home with no support (pathway 0) the ward staff should arrange discharge. ➤ For those who will require reablement, rehabilitation and/or some care followed by further assessment after recovery, (pathways 1 and 2, for up to six weeks), details of their immediate needs will be given to the single point of access (SPA), a case manager will be allocated and a decision made about which pathway will be used. ➤ All people must be transferred to an allocated discharge area or lounge from their ward as soon as possible, to leave hospital the same day. ➤ Case managers will be responsible, in liaison with ward staff, for ensuring (for all those leaving hospital on pathways 1-3): - o Individuals and their families are fully informed of the next steps. - o Arrangements to transport people home from hospital are confirmed. This should be via family or carers, voluntary sector, or taxi, and only as a last resort, non-emergency patient transport (NEPTS). - o 'Settle in' support is provided where needed. - o COVID-19 test results are included in documentation that accompanies the person on discharge (where test has taken place).
Stage three <u>Assessment and care planning at home</u>	➤ Post discharge, the case managers in conjunction with the SPA, will need to work with partners to ensure the staff and infrastructure are available to meet immediate care needs.

	➤ The use of personal budgets should be discussed with the individual and their family as an option, if longer term support is needed. ➤ For all those discharged on pathways 1-3, services providing additional care to that in place pre-admission will be at no cost to the individual for a period not exceeding six weeks. It is the case manager's responsibility to ensure that there is frequent review of the support package and adjustments are made when appropriate. The case manager will liaise with the appropriate professionals to ensure timely assessments for any longer-term care provision and/or associated financial assessments (section 10) or to end support where it is no longer needed.
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Important considerations for all pathways:

- For people where new mental health concerns are considered in light of discharge, psychiatric liaison teams should be contacted by case managers in the first instance to review and assess as appropriate.
- For people with a pre-existing mental health concern who are known to mental health services, their care coordinator or relevant mental health clinician should be involved in their discharge planning to ensure their mental health needs are considered as part of this.
- Duties under the Mental Capacity Act 2005 still apply during this period. DHSC has published [emergency guidance](#) for health and social care staff in England and Wales who are caring for or treating a person who lacks the relevant mental capacity during the COVID-19 pandemic.
- If there is a reason to believe a person may lack the relevant mental capacity to make the decisions about their ongoing care and treatment, a capacity assessment should be carried out before decision about their discharge is made. Where the person is assessed to lack the relevant mental capacity and a decision needs to be made, then there should be a best interest decision made for their ongoing care in line with the usual processes. If the proposed arrangements amount to a deprivation of liberty, Deprivation of Liberty Safeguards in care homes and orders from the Court of Protection for community arrangements still apply. Further information can be found within [DHSC's guidance](#) on this specific area.

- For people identified as being in the last days or weeks of their life, the single point of access will be responsible for overseeing communication with primary care, community services and, where required, community palliative care services to coordinate and facilitate rapid discharge to home or hospice.
- All persons who are homeless or at risk of homelessness on discharge should be referred by acute hospital staff to local authority homelessness/housing options teams, under the requirements of the Homelessness Reduction Act (2017). This duty to refer ensures that services are working together effectively to prevent homelessness by ensuring that peoples' housing needs are considered when they come into contact with public authorities. Further guidance on supporting homeless persons in hospital discharge can be found in the [High Impact Change Model](#) for Managing Transfers of Care.

4. What does this mean for people?

- 4.1 People should expect to receive high quality care from acute and community hospitals, including regular and open sharing of information on the next steps for their care and treatment, as well as clarity on plans and joint decision making processes for post-discharge care. Leaflet A, describing these arrangements, is provided in [Annex B](#) and should be shared with all people on admission to hospital.
- 4.2 Hospital staff will make clear that discharge will be organised as soon as clinically appropriate and people will not be able to stay in a bed after the point where this is clinically necessary. For 95% of people leaving hospital this will mean that (where it is needed), the assessment and organising of ongoing care will take place when they are in their own home.
- 4.3 On the day a person is to be discharged, (following discussions with the person, their family, and any other professionals involved in their care using leaflets B1/B2 in [Annex B](#)), the ward should arrange to escort the person to the hospital discharge area where necessary.
- 4.4 Any ongoing care and support will have been organised, where required, by the case manager; including medication supply, transport home, any volunteer and voluntary sector support and immediate practical measures, such as shopping and turning heating on. For simple discharges (pathway 0) where minimal further support is required, people should expect to be discharged from a discharge area in around two hours. More time may be required for people with more complex care situations that need co-ordinating, though much of the support can be pre-planned during the person's hospital stay through early discharge planning (see the [High Impact Change Model](#) for further detail).
- 4.5 A lead professional or multidisciplinary team, as is suitable for the level of care and support needs, will visit people at home on the day of discharge or the day after to co-ordinate what support is needed in the home environment. If care support is needed on the day of discharge from hospital, this will have been arranged prior to the person leaving the hospital site by a case manager.
- 4.6 Additional care and support needs for all individuals on discharge from hospital (where required) will be provided free of charge for up to six weeks to allow for post-discharge recovery and support services, and any assessments of ongoing care needs and financial eligibility determinations to be made.
- 4.7 For people whose needs are too great to return to their own home (about 5% of people over 65 admitted to hospital), rehabilitation/short term care in a 24 hour bedded care facility will be arranged through the case manager. For people being discharged to a care home bed (short term or permanently) for the first time, this

provision will be provided in a care home, at rates which have been agreed locally by the health and care system and will be free to the individual for up to six weeks (see section 4.6).

- 4.8 DHSC/PHE policy is that people being discharged from hospital to care homes are tested for COVID-19 in a timely manner ahead of being discharged (as set out in the [Coronavirus: adult social care action plan](#)), regardless of whether they were residents of the care home previously or not. Where a test result is still awaited, the person will be discharged if the care home states that it is able to safely isolate the patient as outlined in [Admission and Care of Residents in a Care Home](#) guidance. If this is not possible then alternative accommodation and care for the remainder of the required isolation period needs to be provided by the local authority, funded by the discharge funding.
- 4.9 On the rare occasion that a decision is not reached within this timeframe, the parties paying for the care should continue to do so until the relevant ongoing care assessments are complete. Whatever arrangements are agreed costs from week 7 cannot be charged to the discharge support fund and must be met from existing budgets. CCGs and local authorities should agree an approach to funding of care from the seventh week.
- 4.10 Where an existing local arrangement is in place to agree who funds care while assessments are taking place, then the local authority and the CCG, if they both agree and it is affordable within existing envelopes, may choose to continue with this local funding arrangement from week seven rather than following the arrangements outlined below.
- 4.11 In the absence of an existing locally agreed approach for funding from week seven onwards, it is suggested as a default that the following approach is adopted.
- 4.12 The costs are allocated according to what point in the assessment process has been reached by the end of the six weeks of care, as follows:
- Where the NHS CHC or NHS funded-nursing care (FNC) assessments are delayed, the CCG remains responsible for paying until NHS CHC/FNC assessment is done.
 - After this, where the individual is assessed as not eligible for NHS CHC, responsibility for funding will sit with the local authority in line with existing procedures until the Care Act Assessment is completed, after which normal funding routes will apply.

5. What are the actions for acute care organisations and staff?

Acute providers need to ensure their processes and ways of working have been fully adapted to deliver the discharge to assess model.

5.1 Ward level:

- Clinically led review **of all people** at morning ward round. Discharge planning should start for any person not meeting the clinical criteria to reside in hospital.
- **At least twice daily review of all people** in acute beds to agree who is not required to be in hospital and can therefore be discharged.
- Ensure professional and clinical leadership between nursing, pharmacy, medicine and allied health professions for managing decisions and reducing delay. Use prompts in the box below:

- Does the person require the level of care that they are receiving, or can it be provided in another less intensive setting?
- What value are we adding for the person balanced against the risks of them being away from home?
- What do they need next?
- 'Why not home, why not today' for those who have not reached a point where long-term 24-hour care is required.
- If not home today, then when? – Expected date of discharge from an acute bed

- All people who are suitable for discharge will be added to the discharge list. The Single Point of Access (SPA) will allocate to a discharge pathway. Discharge home should be the default pathway.
- On decision of discharge, the person and their family or carer, and any formal supported housing workers should be involved/informed and receive the relevant leaflet ([see Annex B](#)).
- Transfer people off the ward into a discharge lounge where necessary.

To create a safety-net and increase confidence in discharging, consider:

- Person initiated follow up - give people the direct number of the ward discharged from to call back for advice. Do not suggest going back to their GP or coming to A&E.
- Telephone the following day after discharge to check and offer reassurance/advice.
- Call people back with results of investigations and any changes or updates to an individual's management plan.
- Bring people back under the **same team/speciality**.
- Request community nursing follow up with a specific clinical need.
- Request GPs to follow up in **some selected cases**.

5.2 Hospital Discharge teams:

- Arrange dedicated staff to support and manage all people on pathway 0. This will include:
 - Making arrangements to transport people home from hospital. This should be via family/carers, voluntary sector, or taxi and, only as a last resort, non-emergency patient transport services (NEPTS).
 - Local voluntary sector and volunteering groups helping to ensure people are supported (where needed) actively for the first 48 hours after discharge,
 - ensuring 'Settle in' support is provided where needed.
- In conjunction with local care home providers, develop trusted assessment arrangements to facilitate the prompt return of residents after a hospital stay.

5.3 Hospital clinical and managerial leadership team:

- Create safe and comfortable discharge spaces for people to be transferred to.
- Maintain timely and high-quality transfer of information to Primary Care and other relevant health and care professionals on all people discharged.
- Use change 9 within the [High Impact Change Model](#) to ensure planning and discharge for people with no home to go to, and that no-one is discharged to the street, or to a night shelter.

- Senior clinical staff to be available to support ward and discharge staff with appropriate risk-management and clinical advice arrangements.
- Ensure COVID-19 testing of all people being discharged from hospital to a care home, in advance of a timely discharge (as set out in the [Coronavirus: adult social care action plan](#)). Where a test result is still awaited, the person will be discharged if the care home states that it is able to safely isolate the patient as outlined in [Admission and Care of Residents in a Care Home](#) guidance. If this is not possible then alternative accommodation and care for the remainder of the required isolation period needs to be provided by the local authority, funded by the discharge funding.
- COVID-19 test results should be included in documentation that accompanies the person on discharge.
- Ensure all people identified as being in the last days or weeks of their life are rapidly transferred to the care of community palliative care teams, facilitating prompt discharge to home or a hospice.
- Closely monitor hospital discharge performance data to ensure discharge arrangements are operating effectively and safely across the system, and a high proportion of people on the discharge list achieve a same-day discharge to the most suitable destination for their needs.
- Ensure a live list is available for all agencies to work from and include those suitable for discharge; the number and percentage of people on the list who have left the hospital, and reason of delay for those unable to be discharged in a timely way.

6. What are the actions for providers of community health services?

6.1 Providers of community health services will work closely with other system partners to facilitate timely discharge of people, particularly for pathways 1, 2 and 3. As part of this they should:

- Have an easily accessible single point of contact who will always accept assessments from staff in the hospital and source the care requested, in conjunction with local authorities.
- Deliver enhanced occupational therapy and physiotherapy 7 days a week to reduce the length of time a person needs to remain in a hospital or care home rehabilitation bed.
- Monitor the effectiveness of reablement and rehabilitation.
- Use multi-disciplinary teams on the day a person goes home from hospital, to assess and arrange packages of support.
- Ensure provision of equipment to support discharge.
- Ensure people on pathways 1-3 are tracked and followed up to assess for long term needs at the end of the period of recovery.
- Maintain a focus on supporting timely onward transition of care for persons from community beds, including reablement and rehabilitation packages in home settings. Please refer to the [Community Health Services Standard Operating Procedure](#).
- Support the local authority to ensure that quality of provision is adequate and safe and/or that alternative provision is commissioned
- Ensure that urgent community response services to prevent unnecessary hospital admissions are recorded on the Community Services Dataset (CSDS).
- For people identified as being in the last days or weeks of their life, the single point of access will be responsible for coordinating liaison with primary care, community services and, where required, community palliative care services to coordinate and facilitate prompt discharge to home or hospice.
- Community Palliative Care teams will continue to work with commissioners in retaining the team's responsibility for coordinating and facilitating prompt discharge to home or hospice. End of life care, including palliative care, must continue to be personalised and planned in a holistic way involving the person themselves and their families, social care, community nursing, general practice, occupational therapy, and others.

7. What are the actions for local authorities and Adult Social Care services?

7.1 As part of implementing the discharge to assess model, local authorities are asked to:

- Agree a single lead local authority or point of contact arrangement for each hospital or Trust, ensuring each acute trust and single local coordinator for local discharge to assess pathways has a single point to approach when coordinating the discharge of all people, regardless of where that person lives.
- Work together and pool staffing where appropriate to ensure the best use of resources and prioritisation in relation to people being discharged, respecting appropriate local commissioning routes. Funding will be made available to people with new or additional care needs, and local authorities are enabled by the Care Act (Section 19) to meet urgent needs where they have not completed an assessment and regardless of the person's ordinary residence.
- Work with partners to coordinate activity with local and national voluntary sector organisations to provide services and support to people requiring support around discharge from hospital and subsequent recovery.
- Care packages for those discharged (including commissioning of care home beds) should be jointly commissioned; and the local authority should be the lead commissioner unless otherwise agreed between the CCG and the local authority.
- Take the lead on local care market shaping, including contracting responsibilities (e.g. expanding the capacity in domiciliary care, and reablement services in the local area).
- Work with CQC and other regulators to ensure safeguarding and quality of care, advising NHS colleagues where action is needed to make provision safe or alternatives are needed.
- Engage Local Housing Authority services to provide housing support and advice for persons requiring housing assistance on discharge from hospital.

7.2 Specific responsibilities for Adult Social Care:

- Identify an Executive Lead for the leadership and delivery of the discharge to assess model.

- Make provision for Care Act assessments of need, financial assessments and longer-term care planning if necessary.
- Review the most appropriate setting for social work staff to operate within to support people being discharged. Safeguarding activities should continue to take place in a hospital setting if necessary.
- Provide social care capacity to work alongside local community health services to provide a single point of contact for hospital staff.
- Support real time communication between the hospital and the single point of contact, not just by email.
- Provide capacity to review care provision and change if necessary, at an appropriate point in line with good practice and legal responsibilities.
- Organise any needed isolation capacity for people who do not meet the criteria to remain in hospital, in the event that they require to be discharged to a care home but are unable to be isolated in line with the [Adult Social Care Action Plan](#).
- Work closely with community health providers and local resilience fora over the provision of equipment, such as PPE.
- Support 7-day working for community social care teams (to be commissioned by local authorities).
- Deploy adult social care staff flexibly to support best outcomes for people. This can include support to avoid any immediate bottlenecks in arranging step down care and support in the community, and at the same time focus on maintaining and building capacity in local systems.
- Work with system partners - CCGs, Trusts and ICSs/STPs - to ensure appropriate data collection and that its use supports the best outcomes for individuals. Local authorities have a duty to manage local care markets and for service continuity in relation to provider failure. For the purposes of crisis intervention to avoid hospital admission and for managing hospital discharges this should involve the use of relevant databases for care at home and care homes (currently managed through CQC for domiciliary care and Capacity Tracker for care homes), augmented by systems developed in regions and local intelligence in relation to effectiveness, quality and safeguarding.

8. What are the actions for Clinical Commissioning Groups?

8.1 CCGs supported by Integrated Care Systems (ICSs) or System Transformation Partnerships (STPs) need to support the coordination of activities set out in this framework. Specifically, they must:

- Work in partnership with local authorities to plan and commission sufficient provision to meet the needs of the population based on home first discharge to assess principles.
- Work in partnership with local authorities to coordinate local financial flows for post-discharge care and support, including monitoring all local spend and coordinating local funding arrangements.
- Comply with NHS England and NHS Improvement financial controls and reporting, as set out in Section 10.
- CCGs should follow the guidance on the [Reintroduction of NHS Continuing Healthcare](#).
- Continue to build on recent learning and commissioning arrangements for community palliative care services optimising the best use of all available financial resources including those currently allotted to CHC Fast Track. Enabling community palliative care services to provide palliative and end of life care for those people transferring to, or already in, the community requiring care and support within their own home or a hospice.
- CCGs, working with partner organisations and ICSs/STPs via their capacity tracker leads, should continue to promote the use of the Capacity Tracker tool for care homes, hospices and community rehabilitation bed providers. They should ensure that the operational potential of domiciliary and residential capacity trackers is realised, by their use in health and care system wide discharge planning.

9. What are the actions for care providers?

9.1 Care home providers

- Please refer to separate specific guidance for care home providers on [Admission and care of residents in a care home during COVID-19](#).
- Accept people discharged from hospital when able to do so safely. Care providers should consider whether they are able to meet the prospective clients' needs, taking into account relevant CQC regulations and provider duties (e.g. ability to isolate, sufficient PPE, and access to staff and resident testing). Ensure isolation of residents transferred from a hospital setting in line with care home isolation and infection prevention guidance (above) and be familiar with alerting mechanisms to local Health Protection Teams in the event of positive COVID-19 test results.
- Maintain capacity and identify vacancies that can be used for hospital discharge purposes, utilising the Capacity Tracker tool to share information with partner organisations.
- Where Trusted Assessment relationships and arrangements are not in place with acute providers, rapidly work with the discharge team to implement these approaches.
- If providing reablement or rehabilitation, then monitor and share the effectiveness of that service.

9.2 Domiciliary care providers

- Identify capacity to adult social care contract leads, that can be used for hospital discharge purposes or follow on care from reablement services.
- Ensure sufficiency of PPE and COVID-19 testing, the ability to isolate and that assessment and care planning for the future are in place (for example, by ensuring all providers know who to contact to get help, and that robust workforce contingency plans ensure continuity of care).
- If providing reablement or rehabilitation, then monitor and share the effectiveness of that service.

9.3 Pathways 1, 2 and 3

- Of those people discharged to short-term reablement/rehabilitation pathways, approximately 35% are likely to require an ongoing package of care at home, or placement in a 24-hour residential or nursing setting.
- It is essential that people on these pathways are tracked and assessed through and after a period of recovery. Longer-term care (appropriate supported housing, care package or care home placement) must be made available at the right time to ensure the best outcomes for individuals, and the best use of system resources.

9.4 Community hospitals

It is vital that discharges from community hospitals are increased and delays reduced with the same approach and action taken as in acute settings. This includes:

- A daily clinical review of every person's plan, focusing on three questions:
 - Why not home?
 - What needs to be different to make this possible at home?
 - Why not today?
- The review process should explore why people require rehabilitation in a bedded setting. It is accepted that the majority of people will be medically stable in this setting.
- All people should have an expected date of discharge (EDD) and be fully involved with their discharge planning. It is essential that expectations are set at the point of transfer or admission.
- The review should specifically look at whether people can be supported at home. The default assumption will be discharge home today.
- All actions from the review should be noted and aimed to be completed by the end of the day.
- Keep the Capacity Tracker updated with live status of bed vacancies daily.
- Use and submit the daily data collection of data as described in the 'COVID-19: new EPRR data collection during COVID-19 incident for community hospital bed providers' letter, issued on 15 June 2020.

9.5 Short-term placement for people who require 24-hour care and support

- For people who need a 24-hour care setting, it is essential they are assigned a case manager (social worker, discharge team nurse or CHC co-ordinator) who will review them regularly using the same questions as for community hospitals.
- Discharge should be arranged as soon as possible to their own home and packages of support made available.

9.6 **Short term rehabilitation/reablement-at-home review**

- Using a professional supervision/case management model the case manager must review all people on their caseloads daily. The team identifies all people who have been on caseloads for an extended period.
- These people are discussed using the following questions:
 - What is our current aim of support?
 - Have we met this? If not, what is going to change to enable us to meet this aim?
 - Are we best placed to support this need? Is there an alternative?
 - Can we safely discharge this person?
- Actions from the discussion are recorded and actions followed up daily.

10. Finance support and funding flows

10.1 The Government has agreed to fund, via the NHS:

- The cost of post-discharge recovery and support services, such as rehabilitation and reablement (in addition to what was provided prior to admission) for up to a maximum of six weeks to help people return to the quality of life they had prior to their most recent admission.
- To support urgent community response services for people who would otherwise be admitted into hospital. These will typically provide urgent support within two hours and for a limited time (typically 48 hours) and, if required, transition into other ongoing care and support pathways.

10.2 The additional funding available to CCGs to support delivery of the services described in this guidance should only be used to fund activity arising from this guidance that is over and above the activity normally commissioned by CCGs and local authorities.

10.3 Eligibility funding assessments for care and health needs should not take place in acute hospital settings. NHSE/I will ensure there is sufficient funding to support CCGs and their local authority partners to commission the enhanced discharge support outlined in this guidance. CCGs are expected to ensure that an appropriate rate is paid for this support working with their local authority commissioners. This agreed rate may need to reflect the actual cost of care, particularly where some care provider capacity being utilised, would previously have been self-funded from the point of hospital discharge.

10.4 Under the provisions of this scheme, additional costs of post-discharge recovery and support services will be funded until the person's long-term care needs are assessed, or for up to the first six weeks if the assessment is not completed by that time. It is expected that an assessment for ongoing health and care needs takes place within six weeks of discharge and that a decision is made about how this care will be funded by this date. CCGs will not be able to draw down funding from the discharge support arrangements after the end of the sixth week to fund any care package beyond this date.

10.5 On the rare occasion that a decision is not reached within this timeframe the parties paying for the care should continue to do so until the relevant ongoing care assessments are complete. Whatever arrangements are agreed, costs from week seven cannot be charged to the discharge support fund and must be met from existing budgets. CCGs and local authorities should agree an approach to funding of care from the seventh week.

- 10.6 Where an existing local arrangement is in place to agree who funds care while assessments are taking place, then the local authority and the CCG, if they both agree and it is affordable within existing envelopes, may choose to continue with this local funding arrangement from week seven rather than following the arrangements in section 10.8.
- 10.7 In the absence of an existing locally agreed approach (see section 10.5–10.6) for funding from week seven onwards, it is suggested as a default that the following approach is adopted:
- 10.8 The costs are allocated according to what point in the assessment process has been reached by the end of the six weeks of care, as follows:
- Where the NHS CHC or FNC assessments are delayed, the CCG remain responsible for paying until NHS CHC/FNC assessment is done.
 - After this, the local authority should pay until the Care Act Assessment is completed, after which normal funding routes will apply.
- 10.9 For people discharged from hospital or assigned a package of short-term care to avoid admission into hospital from 1 September 2020, this funding arrangement will apply, replacing the previous arrangements introduced on 19 March 2020 as part of the COVID-19 Discharge Guidance. The approach to transition from the COVID-19 arrangements to these new arrangements is set out below.
- 10.10 Where a person was in receipt of a care package prior to admission to hospital and is discharged with a package of short term reablement, this funding will pay for those additional costs (where these are over and above the activity that is ordinarily commissioned by CCGs and local authorities). This would apply regardless of whether or not the person was still being cared for by the same care provider.
- 10.11 The additional funding will **not** pay for:
- Long term care needs following completion of a Care Act and/or NHS CHC assessment.
 - Social care or NHS CHC packages that are restarted following discharge from hospital at the same level as that already delivered prior to admission to hospital.
 - Pre-existing (planned) local authority or CCG expenditure on discharge services.

Transition arrangements

10.12 This funding support will commence from 1 September 2020 and will reimburse, via CCGs, up to six weeks of costs of out-of-hospital care and support that arise as a result of the approach outlined in this document (both new packages and enhancements to existing packages), where it is provided to people on or later than this date. Any person already receiving out-of-hospital care and support that started before 1 September 2020 will be expected to be funded through pre-existing mechanisms and sources of funding (including COVID-19 discharge funding), where the care provided continues on the same basis as prior to admission.

10.13 These new funding arrangements will apply up until 31 March 2021.

People funded through the COVID-19 Discharge Guidance funding arrangements which commenced on 19 March 2020, who enter a care package between 19 March and 31 August 2020, will continue to be funded through those arrangements. Relevant assessments should be completed for these individuals as soon as is practical to ensure transition to normal funding arrangements.

Proposed finance route from CCGs for additional discharge support services

10.14 Procurement and contracting rules continue to apply. Local commissioners should agree the most appropriate route to deliver the enhanced discharge support in their area. Additional financial support provided to CCGs and local authorities should be pooled locally using existing statutory mechanisms. Under section 75 of the NHS Act 2006 and associated regulations, CCGs and local authorities can enter into partnership agreements that allow for local government to perform health related functions where this will likely lead to an improvement in the way these functions are discharged.

10.15 Where systems decide that an enhanced supply of out-of-hospital care and support services will be commissioned via the local authority, the existing section 75 agreements can be extended or amended to include these services and functions and the local authority should commission the health and social care activity on behalf of the system. Similarly, where a CCG is already acting as a lead commissioner for integrated health and care, partners can agree that existing section 75 arrangements can be varied to allow them to commission social care services.

- 10.16 Where CCGs and local government agree, BCF section 75 agreements can be extended or varied for this purpose³. A model template was developed for the COVID-19 Discharge Service Requirements for areas to adapt locally to vary existing BCF Section 75 agreements and this document can be used as the basis for implementing these arrangements.
- 10.17 The funding provided should be separately identified within the agreement and monitored to ensure funding flows correctly. It should be pooled alongside existing local authority and CCG planned expenditure on discharge support, and this funding is intended to meet additional costs only. Support provided and agreed budgets from this funding should be recorded at individual level. CCGs should continue funding (through their existing budgets) existing intermediate care support services on discharge from hospital. Where the enhanced care services are most appropriately commissioned directly by NHS commissioners, these should be placed under existing contractual arrangements with providers but invoiced separately to ensure that enhanced discharge support funding is identifiable. This care should be paid for from the additional funding set out in this section.
- 10.18 Commissioners should work with providers of discharge services to ensure that extending existing contracts will be financially sustainable for those providers and consider mitigating actions where there is a risk that they will not be.

Reimbursement routes and cashflow

- 10.19 CCGs should ensure that both they and any local authorities commissioning on their behalf reimburse their providers in a timely fashion, reflecting differing cash-flow requirements of those providers – paying particular consideration to smaller providers. Local authority and CCG commissioners should refer to guidance on [Social care provider resilience during COVID-19](#).
- 10.20 NHSE/I expect ordinary financial controls to be maintained with respect to invoicing, raising of purchase orders and authorising payments.
- 10.21 NHSE/I will reimburse CCGs through the monthly allocation process. CCGs should, from the commencement date, maintain a record of the costs and activity associated with the enhanced discharge process so that they can submit a claim for additional payment for this from NHSE/I. This should include expenditure relating to urgent community response services to prevent unnecessary hospital admissions, where

³ The Better Care Fund Policy allocations for the [CCG minimum contribution](#) and the [improved Better Care Fund](#) have been made public.

this is over and above the level of activity for these services that would ordinarily be commissioned.

- 10.22 Whichever model is followed, CCGs should record the costs associated with this and should expect to be asked for monthly updates on the costs of these services.

Monitoring of funding and overall activity

- 10.23 For the purposes of definition, the arrangements prior to 1 September 2020 (detailed in the 19 March 2020 hospital discharge guidance) will be termed 'scheme 1' and the arrangements from 1 September 2020 will be defined as 'scheme 2'. The scheme funding arrangements will apply up until 31 March 2021.
- 10.24 From 1 September 2020 there will continue to be people from scheme 1 and scheme 2 receiving packages of care. People in scheme 1 will continue to receive their package of care, as defined by the 19 March 2020 hospital discharge guidance arrangements. Scheme 1 closes at midnight on 31 August 2020. Each scheme will be monitored separately.
- 10.25 After 1 September 2020 no-one will enter scheme 1 and as people leave this scheme having had (for instance) a means tested or CHC assessment, data will track decreasing activity and spend.

Collection and Frequency

- 10.26 For each scheme data will be collected for the following care settings or services:

- a) Care Home
- b) Other care accommodation
- c) Domiciliary/Home care
- d) Reablement/intermediate care
- e) Hospice
- f) Other (please specify)

- 10.27 It is important to differentiate and understand who is in which scheme to ensure an accurate return. Each scheme will be submitted on a separate template. Data will continue to be collected from local authorities and CCGs on a monthly basis.

Gathering more granular activity information

- 10.28 To further understand the pathway of people receiving the six-weeks of funded non-hospital care and support, more granular information will also be gathered. This will include understanding differences in discharge pathway spend now and pre-COVID-19. Due to the significant data burden of all systems returning information of all people and their packages of care, work will be done with a sample of systems each month.

11. Reporting and performance management

- 11.1 Current performance standards on Delayed Transfers of Care (DTOC) monthly reported delays were suspended from Thursday 19th March 2020. There are no plans to return to this reporting arrangement at present, and systems should not be counting, recording or charging local authorities under the DTOC regime.
- 11.2 In place of this, NHS providers are expected to continue to provide daily reporting through the Strategic Data Collection Service (SDCS) in the short term. These arrangements identify the numbers of people leaving hospital and where they are discharged to, and the reasons why people continue to remain in hospital.
- 11.3 This information is required to allow us to track the effectiveness of the policies described in this document. We are working on improving situation reporting and will notify providers of new requirements as and when appropriate. We are also exploring an automated system of collection of this data and, subject to further engagement with providers and other stakeholders, we hope to roll this out in 2021.
- 11.4 CCGs will be required to submit monthly financial spend to NHSE/I for reimbursement.
- 11.5 Local systems should ensure that data and intelligence about the sufficiency, suitability and sustainability of care and health services are shared, so as to maximise the effectiveness of services, outcomes for individuals and populations and the overall use of resources. This should include supporting data reporting from care providers, as outlined in the [Support for Care Homes](#) letter issued by the Government on 14 May 2020.

Data collection guidance

- 11.6 Alongside revision to this guidance, the opportunity has also been taken to update and refresh the daily acute discharge data collection, taking account of suggestions and feedback received since the original collection launched on 8 April 2020.
- 11.7 It is intended that once arrangements are made, including amending the data collection template on the SDCS portal, we will email out to data submitters to give at least one week's notice before we move to collecting data based on the revised questions.

- 11.8 Each of the revised questions for the data collection are reproduced below, with commentary beneath each one in bold. **We are seeking data for all individuals, and a number of questions (5, 6, 7 and 8) also ask about those with a length of stay of 21 days or over, and one question (9) asks about those with a length of stay of 14 days or over.**
- 11.9 It is worth noting that those with a length of stay of 14 days or over are a subset of total patients and will be counted within them, and those with a length of stay of 21 days or over are a subset of total patients and also a subset of the number of patients with a length of stay of 14 days or over.
- 11.10 Of the revised questions, below, numbers 1 to 7 should be collected daily and the data submitted on SDCS by 11.00 the following day. Questions 8 and 9 are weekly collections and should be submitted on SDCS each Friday by 11.00.
- 1) The number of people who meet the criteria to reside in total.
And the total then split by the number falling into the following reasons to reside categories:
 - a. Physiology
 - b. Treatment
 - c. Recovery
 - d. Function
 - 2) The number of people who meet the criteria to be discharged that day.
These are the people who do not meet the criteria to reside as set out in [Annex A](#). The reference to “discharged that day” refers to the period from midnight on the previous day to midnight on the current day for which the data is being collected.
 - 3) The number of people who have been or will be discharged by 17.00.
This refers to the patient numbers reported for question 2, and how many of those were actually discharged by 17.00 on the day for which data is being collected.
 - 4) Of the people who have been or will be discharged by 17.00, the number intended to be discharged to the following locations:
 - a. Home
 - b. Care Home
 - c. Hospice
 - d. Rehabilitation bed
 - e. Other

For 4d please report all discharges from acute beds to rehabilitation beds, even where the person continues to be treated by the same Trust.

- 5) Of the total number of people who have a length of stay of 21 days and over the number who:
- a. Meet the criteria to reside in total, and split by the number falling into the following reasons to reside categories:
 - i. Physiology
 - ii. Treatment
 - iii. Recovery
 - iv. Function
 - b. Meet the criteria to be discharged

For 5a, please report the number of people with a length of stay over 21 days who meet the criteria to remain in hospital, and then split this down into categories i. to iv.

- 6) The number of people who have a length of stay of 21 days and over who have been or will be discharged by 17.00.

This refers to the patient numbers reported for question 5b, and how many of those were actually discharged by 17.00 on the day for which data is being collected.

- 7) Of the people who have a length of stay of 21 days and over who have been or will be discharged by 17.00, the number intended to be discharged to the following locations:
- a. Home
 - b. Care Home
 - c. Hospice
 - d. Rehabilitation bed
 - e. Other

For 7d please report all discharges from acute beds to rehabilitation beds, even where the person continues to be treated by the same Trust.

Data for question 8, below, should be collected by a weekly review process that is similar to the former Discharge Patient Tracking List (DPTL) process, and be submitted weekly each Friday.

- 8) Of the total number of people who have a length of stay of **21 days or over** who have been judged to meet the criteria to be discharged but who continue to reside in hospital:

- a. The number of additional days in total they have remained in hospital since the meeting of the criteria to be discharged decision was made.
- b. A breakdown showing the number of people against each of the following reasons for why they continue to reside, despite meeting the criteria to be discharged:
 - i. Declared as not meeting the criteria to reside at morning ward round and then later in day meets the criteria to reside so discharge stopped.
 - ii. Awaiting a medical decision/intervention including writing the discharge summary.
 - iii. Awaiting therapy decision to discharge (no acute medical or nursing intervention required; therapist stating that person requires further rehabilitation in the acute hospital).
 - iv. Awaiting referral to community single point of access.
 - v. Awaiting medicines to take home.
 - vi. Awaiting transport.
 - vii. Awaiting confirmation from community hub/single point of access that referral received and actioned. The single point of access should make the decision on which pathway will best meet the needs as described by the hospital not prescribed by the hospital.
 - viii. Pathway 1: awaiting availability of resource for assessment and start of care at home.
 - ix. Pathway 2: awaiting availability of rehabilitation bed in community hospital or other bedded setting.
 - x. Pathway 3: awaiting availability of a bed in a residential or nursing home that is likely to be a permanent placement.
 - xi. Awaiting community equipment and adaptations to housing.
 - xii. Individual/family not in agreement with discharge plans.
 - xiii. Homeless/no right of recourse to public funds/no place to discharge to.
 - xiv. Safeguarding concern preventing discharge or Court of Protection.
 - xv. Repatriation/transfer to another acute trust for specialist treatment or ongoing treatment.

Data for question 9 should also be collected by a weekly review process that is similar to the former Discharge Patient Tracking List (DPTL) process and be submitted weekly each Friday.

- 9) Of the total number of patients who have a length of stay of **14 days or over** who have been judged to meet the criteria to be discharged but who continue to reside in hospital:
 - a. The number of additional days in total they have remained in hospital since the meeting of the criteria to be discharged decision was made.

- b. A breakdown showing the number of patients against each of the following reasons for why they continue to reside, despite meeting the criteria to be discharged:
 - i. Declared as not meeting the criteria to reside at morning ward round and then later in day meets the criteria to reside so discharge stopped.
 - ii. Awaiting a medical decision/intervention including writing the discharge summary.
 - iii. Awaiting therapy decision to discharge (no acute medical or nursing intervention required; therapist stating that person requires further rehabilitation in the acute hospital).
 - iv. Awaiting referral to community single point of access.
 - v. Awaiting medicines to take home.
 - vi. Awaiting transport.
 - vii. Awaiting confirmation from community hub/single point of access that referral received and actioned. The single point of access should make the decision on which pathway will best meet the needs as described by the hospital not prescribed by the hospital.
 - viii. Pathway 1: awaiting availability of resource for assessment and start of care at home.
 - ix. Pathway 2: awaiting availability of rehabilitation/reablement/recovery bed in community hospital or other bedded setting.
 - x. Pathway 3: awaiting availability of bed in a residential or nursing home that is likely to be a permanent placement.
 - xi. Awaiting community equipment and adaptations to housing.
 - xii. Patient/family not in agreement with discharge plans.
 - xiii. Homeless/no right of recourse to public funds/no place to discharge to.
 - xiv. Safeguarding concern preventing discharge or Court of Protection.
 - xv. Repatriation/transfer to another acute trust for specialist treatment or ongoing treatment.

12. Additional resources and support

- 12.1 For queries relating to this guidance, please contact england.d2a@nhs.net
- 12.2 This document should be read alongside the 2015 [NICE guideline, transition between inpatient hospital settings and community or care home settings for adults with social care needs](#).
- 12.3 Discharge to assess also forms part of the [High Impact Change Model \(HICM\)](#) for hospital discharge.
- 12.4 For further detail on discharge to assess, please see the [D2A Quick Guide](#).
- 12.5 [Shared guidance to local authority commissioners](#) from the Association of Directors of Adult Social Services (ADASS), the Local Government Association (LGA) and the Care Provider Alliance (CPA).
- 12.6 [COVID-19 action plan for adult social care](#).
- 12.7 Newton Europe publications:
[Why Not Home, Why Not Today?](#)
[People First: Manage What Matters](#).
- 12.8 [Community Health and care discharge and crisis care model: an investment in reablement](#).



Annex A: Criteria to Reside - Maintaining good decision making in acute settings

Every person on every general ward should be reviewed on a twice daily ward round to determine the following. If the answer to each question is 'no', active consideration for discharge to a less acute setting must be made.

Requiring ITU or HDU care?

Requiring oxygen therapy/NIV?

Requiring intravenous fluids?

**NEWS2 > 3? (clinical judgement required in persons with AF
and/or chronic respiratory disease)**

Diminished level of consciousness where recovery realistic?

**Acute functional impairment in excess of home/community care
provision?**

Last hours of life?

Requiring intravenous medication > b.d. (including analgesia)?

Undergone lower limb surgery within 48hrs?

Undergone thorax-abdominal/pelvic surgery with 72 hrs?

Within 24hrs of an invasive procedure? (with attendant risk of acute life- threatening deterioration)

Clinical exceptions will occur but must be warranted and justified. Recording the rationale will assist meaningful, time efficient review.

Review/challenge questions for the clinical team:

- Is the person medically optimised? – (Don't use 'medically fit' or 'back to baseline').
- What management can be continued as ambulatory – e.g. heart failure treatment?
- What management can be continued outside the hospital with community/district nurses? e.g. IV antibiotics?
- Persons with low NEWS (0-4) scores – can they be discharged with suitable follow up?
 - If not scoring 3 on any one parameter – e.g. pulse rate greater than 130
 - If their oxygen needs can be met at home
 - Stable and not needing frequent observations every 4 hours or less
 - Not needing any medical/nursing care after 8pm
 - People waiting for results – can they come back, or can they be phoned through?
 - Repeat bloods – can they be done after discharge in an alternative setting?
 - People waiting for investigations – can they go home and come back as outpatients with the same waiting as inpatients?

Criteria-led discharge:

- Can a nurse or allied health care professional discharge without a further review if criteria are well written out?
- Can a junior doctor discharge without a further review if criteria are clearly documented?
- How can we contact the consultant directly if criteria are only slightly out of range and require clarification?

Annex B: Discharge choice leaflets

It is recognised that issues of individuals choice and engagement can often be significant barriers to hospital discharge where there are ongoing social care needs after discharge (particularly if moving to a residential or nursing home). The following leaflets have been produced to support the communication of this message and are [separately available for download](#). They are available in 12 languages and in Easy Read.

- Leaflet A – to be shared and explained to all persons on admission to hospital
- Leaflet B – to be shared and explained to all persons prior to discharge, this is split into leaflets:
 - Leaflet B1 for persons who are being discharged to their usual place of residence
 - Leaflet B2 for persons moving on to further non-acute bedded care

Discharge choice Leaflet A – on admission to hospital



HM Government



Hospital discharge information

Once you are better, your recovery will be faster back in your own home. It is also important that our hospitals are able to look after people that need hospital care. Due to this, once you no longer need care in hospital, as decided by the health team looking after you, you will be discharged. It is always our priority to discharge you to the best possible place to support your recovery.

In most cases this will be to your home. You might need some extra support to help your recovery or practical help, such as with shopping.

If you require more complex care, this could be in another bed in the community.

Your needs and discharge arrangements will be discussed with you and your family, if you would like them to be involved.

Prepare for discharge

- Speak to staff about your care plan after discharge.
- Include relatives and friends in the conversation – can they offer support to you once you are home?
- What extra help might you need at home?

Discharge choice Leaflet B1 – for persons who are being discharged to their usual place of residence



Your hospital discharge: going home



This leaflet explains why you are being discharged from hospital and what you might expect after your discharge.

Why am I being discharged from hospital?

You are being discharged from hospital as your health team have agreed that you are now able to return home.

Why can't I stay in hospital?

It is important that our hospitals are able to look after people that need hospital care. Due to this, once you no longer need care in hospital, as decided by the health team looking after you, you will be discharged. It is always our priority to discharge you to the best possible place to support your recovery.

You will not be able to remain in hospital if you choose not to accept the care that is being offered to you.

What can I expect?

Your health team will discuss discharge and transport arrangements with you (and a family member, friend or carer if you wish). If you require care and support when you get home, this will be arranged.

If you need more care now than when you came into hospital, this additional care will be provided free of charge for up to six weeks to support your recovery. After this time, you may be required to contribute towards the cost of your care.

Who can I contact?

After you have been discharged, if you have any concerns or need to speak to someone about your care, you can contact **<Insert locally agreed details e.g. team name and contact number>**

www.nhs.uk

Discharge choice Leaflet B2 – for persons moving on to further non-acute bedded care



HM Government



Your hospital discharge: another place of care



This leaflet explains why you are being discharged from hospital and what you might expect after your discharge.

Why am I being discharged from hospital?

You are being discharged as your health team have agreed that you are now able to continue your recovery in another care setting, outside of hospital.

Why can't I stay in hospital?

It is important that our hospitals are able to look after people that need hospital care. Due to this, once you no longer need care in hospital, as decided by the health team looking after you, you will be discharged. It is always our priority to discharge you to the best possible place to support your recovery. You will not be able to remain in hospital if you choose not to accept the care that is being offered to you.

What can I expect?

Your discharge and transport arrangements will be discussed with you (and a family member or carer if you wish) and you will be discharged with the care and support you need to a bed in the community.

If you need more care now than when you came into hospital, this additional care will be provided free of charge for up to six weeks to support your recovery. After this time, you may be required to contribute towards the cost of your care.

It is possible that you may be moved more than once after your discharge. This is because we will be trying to find the best place for your ongoing care. Your health team are here to answer any questions you might have.

Who can I contact?

After you have been discharged, if you have any concerns or need to speak to someone about your care, you can get in touch with **<Insert locally agreed details e.g. team name and contact number>**

www.nhs.uk

Discharge choice Leaflet B3 – for persons' family member or person who will provide care for them in all scenarios



Looking after family or friends after they leave hospital?

This leaflet lists useful advice for family and friends of people needing ongoing care or support with day-to-day life. Support may be in the home or remotely (e.g. by phone), and might include:

- Emotional support like helping someone manage anxiety or mental health
- Housework like cooking, cleaning or other chores
- Personal support like help moving around, washing, eating or getting dressed
- Assistance with getting essential items like medicine or food, or
- Help to manage money, paid care or other services



What to consider if you are looking after someone:

1. Get help from others with caring and everyday tasks:

- Try not to do everything yourself! Speak to friends and family about what support the person needs and what others can do to help. Can they share any tasks?
- Go to the Carers UK and Carers Trust websites for information about support available. Carers UK also have an online forum where you can speak to other carers, and a free helpline, open Monday to Friday, 9am to 6pm on 0808 808 777. Carers UK website <https://www.carersuk.org/>
- If you are employed, talk to your employer about managing work whilst caring. You may be able to arrange flexible working and many employers offer other ways of making things easier.
- If you are at school, college or university, let them know you are caring for someone so they can help you manage your studies. Carers Trust has lots of helpful advice for young people looking after family members or friends. Carers Trust website <https://carers.org/>
- Check what your council or local authority can offer. Find their websites using the online postcode tool at www.gov.uk/find-local-council. Services may change during the pandemic.
- Get specialist advice about caring from condition-related organisations like Alzheimer's Society, Age UK, MIND and others. Many offer [support](#) for carers too.

2. Look after your health as well as the person you support: It's important to look after yourself to stay healthy and avoid burning out. Eat a balanced diet, get enough sleep and try to make time each day for physical activity. Taking time for yourself to exercise or take a few breathers can relieve stress and help you manage each day. Check the NHS 'Every Mind Matters' website <https://www.nhs.uk/oneyou/every-mind-matters/> for more tips. If your own health or the health of the person you support gets worse, with coronavirus or another illness, talk to your GP or call NHS 111.

3. Think ahead to make care manageable if things change: Write down what care the person needs and what others should do if you can't continue providing care for any reason. It's important that others can easily find your plan and quickly understand what needs to be done if you aren't there. Carers UK have advice on their website on how to make your plan.

4. Read the Government guidance for unpaid carers: For more detailed advice on caring for friends or family during coronavirus search for 'unpaid care coronavirus gov.uk' online.

5. Register for extra support from NHS volunteers: Carers as well as those they care for can get a range of help including with shopping and other support by calling 0808 196 3646.

Annex C: Overview of decision making and escalation

Overview of Discharge Decision Making & Escalation to ensure hospital and community beds are freed up



Key Steps	Decision Points & Responsibilities	Route of Escalation
Morning Ward Round	Medical decision to discharge – discharge pathway confirmed (Lead: Senior Doctor in ward)	Executive Director in Acute
Waiting in discharge area in hospital	Case manager agreed (Lead: Local coordinator in acute)	Executive Director in Acute
	Discharge activities agreed incl. transport and medication (Lead: Single coordinator in acute)	
Patient leaves hospital or community bed	Transport to home or bedded setting (Lead: Single coordinator in acute)	Executive Director in Acute (for acute issues) and Director of Community Services (for community health issues)

Overview of Discharge Decision Making & Escalation to ensure assessment and support is provided



Key Steps	Decision Points & Responsibilities	Route of Escalation	
Assessment at home	Trusted assessor visit for those on pathway 1 – acute or community health care professional (Lead: Single coordinator in acute)	Executive Director in Acute (for acute issues) and Executive Director of Community Services (for community health issues) and Director of Adult Social Services (for social care issues)	Gold Command EPRR Team
Care provided as needed	At home support provided as needed by health and/or social care (Lead: Single coordinator in acute)	Executive Director of Community Services (for community health issues) and Executive Director of Adult Social Services (for social care issues)	Gold Command EPRR Team
Review post short team support	Ongoing short term support as needed by health and/or social care or discharge from all support (Lead: Single coordinator in acute)	Executive Director of Community Services (for community health issues) and Executive Director of Adult Social Services (for social care issues)	Gold Command EPRR Team

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