Home First / Discharge to Assess:

A Practical Guide for Achieving Good Outcomes for People Leaving Hospital

2022/23 (version 1)

Contents

Purpose of this guide

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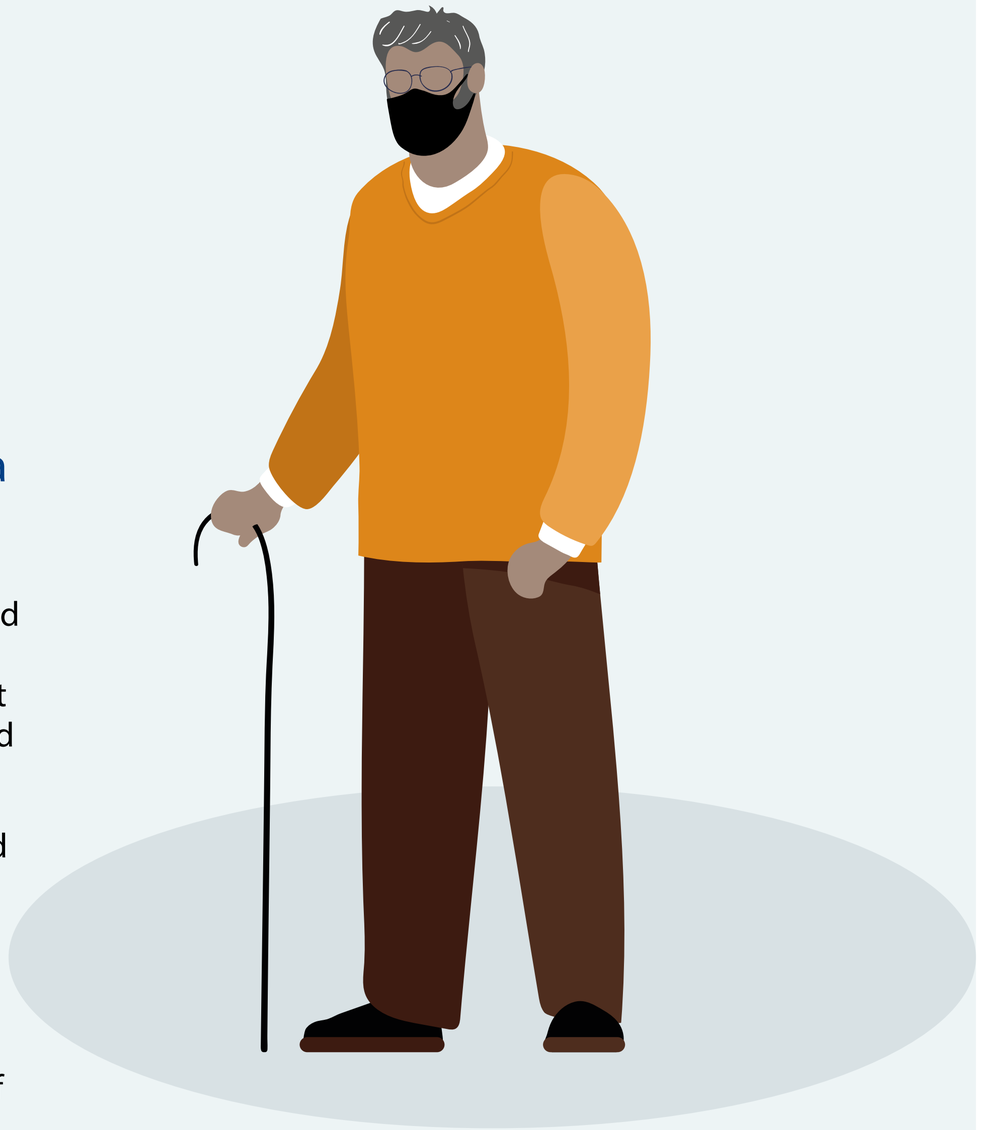
This guide, which is based on Hospital discharge and community support guidance, describes the practical steps that should be taken by local health and social care systems at an operational level to implement a Discharge to Assess model for people leaving hospital, where systems have decided to adopt such a model that is affordable within existing local budgets.



The guide applies to any adult (aged 18 years and over) inpatient (except for maternity patients) discharged from an NHS acute or community setting in England, including acute hospitals and virtual wards, and community hospitals and community rehabilitation units. Discharges from mental health hospitals are not within scope. However mental health trusts are encouraged to consider which principles could be adapted to improve discharge practice in mental health care pathways.

Where local health and social care systems choose to adopt a Discharge to Assess model, the focus should be on discharging people home where possible following what is known as a Home First approach. Once settled back into their homes, and after a short period of care and support including reablement and/or rehabilitation if needed, only then should assessments be fully completed to establish long-term or ongoing care and support needs, if required. This should include consideration of an NHS Continuing Healthcare (NHS CHC) assessment and Care Act 2014 assessment. Those with a rapidly deteriorating condition that may be entering a terminal phase may require 'fast-tracking' for the immediate provision of NHS CHC.

Core components of Home First / Discharge to Assess

Each health and social care system has a unique configuration of organisations and specific demographics in their population and will need to deliver the Home First / Discharge to Assess model in a way that suits their population. As such, this guidance should be adapted to meet local needs. There are, however, core components that should be observed by all systems choosing to adopt a Discharge to Assess model:

1. Home (or usual place of residence) should always be the first option on discharge.

2. People should only remain in an acute hospital whilst they are getting treatment that they could not receive anywhere other than that setting (see Annex A: Criteria to Reside). To stay any longer than this may have a detrimental effect on them and deny others a needed service.

3. Assessments of long-term or ongoing care and support needs should not be made in an acute hospital. Such assessments will not fully reflect the abilities of people and may well lead to the over-prescription of care and support.

4. A time-limited therapy-led period of care and support, including reablement and/or rehabilitation, should be provided to those who need it on discharge. This includes those with palliative or end of life care needs. This should help people to maximise their independence and meet their personal goals.

Keeping these core components in mind when designing, implementing or embedding Home First / Discharge to Assess approaches will help achieve better outcomes for people and the wider system.

What a good hospital discharge looks like

What a good hospital discharge looks like

Home First / Discharge to Assess

The following pages (pages 8-12) set out the principles and foundations of Home First / Discharge to Assess for systems choosing to adopt such a model where affordable within existing local budgets. Figure 1 outlines the principles which underpin an effective Discharge to Assess model. Figure 2 outlines the foundations of Home First and demonstrates the relationship with the High Impact Change Model and Discharge to Assess pathways.

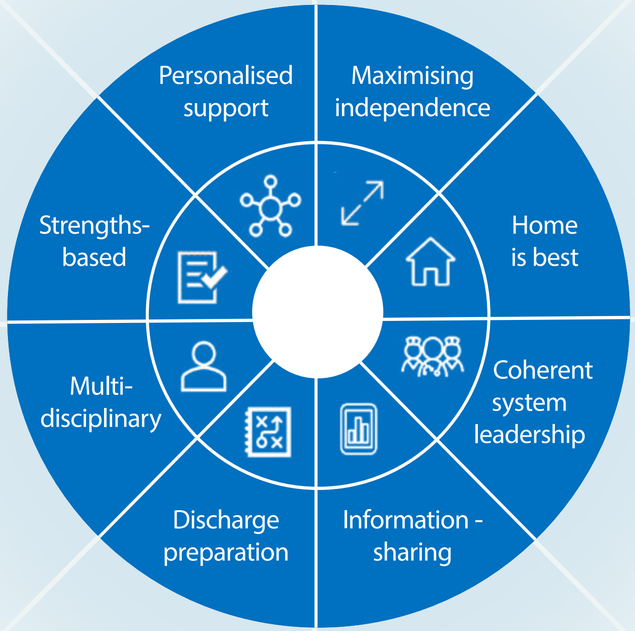
The focus is on getting people home, ideally straight from discharge or, if not, then via another place of care on an interim basis. People with onward care and support needs, including those with palliative or end of life care needs, should receive a short period of care and support, including reablement and/or rehabilitation, to help them recover, as much as possible, from the incident which led to their hospital stay. After this recovery period, assessments to establish long-term or ongoing care and support needs and funding eligibility may take place, if required. Those with a rapidly deteriorating condition that may be entering a terminal phase may require 'fast-tracking' for the immediate provision of NHS CHC.

Figure 1:
Principles of Home First / Discharge to Assess

Integrated, timely, personalised care rather than care that is most convenient for individual organisations. Services that say 'yes' and tailor their response to the needs of the individual. People with ongoing needs can access care and support via a personal health budget, personal budget or integrated personal budget, as well as via commissioned services.

Maximising independence for everyone receiving post-discharge recovery and support services. Many people will benefit from a short, intensive period of support aimed at reducing or eliminating longer-term needs for care.

Strengths-based assessment proportionate to the stage of recovery the individual has reached, involving the individual (and/or others as appropriate). This will be appropriate to the level of decision required and undertaken at the right time and in the right place to get an accurate picture of what is needed. Describing the needs of the individual - not prescribing.



Home is best for 95% of older people leaving hospital for recovery and any further assessment of needs.

Flexible multi-disciplinary working involving health, social care, housing, the independent sector and the voluntary sector, creating a culture across organisations that enables personalised services to be wrapped round the individual.

Positive, collaborative system leadership with a clearly articulated vision, trust between partners, and a sense of mutual endeavour to solve problems and blur boundaries as necessary. Success is judged as a system based on the outcomes achieved for individuals using services - not on individual organisational indicators.

Preparation for discharge begins at the point of admission creating a culture which recognises multiple and complex needs, including a person-centred informed response. A culture of partnership working is in place to enable appropriate discharge planning and onward assessment.

Communication and information-sharing with the individual and their family/friends/carers, and between those organisations, assessing, commissioning and providing care and support.

What a good hospital discharge looks like, continued

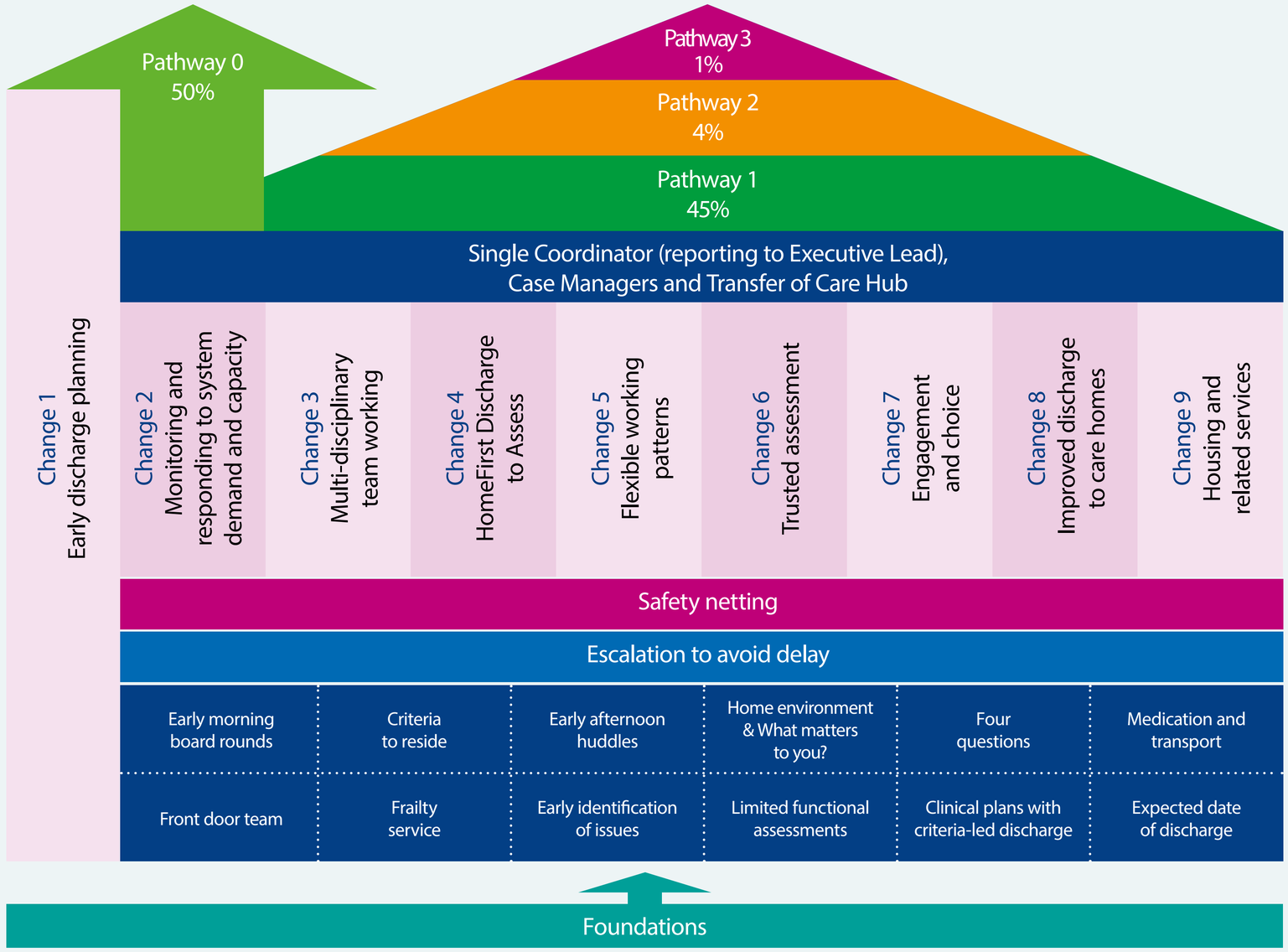
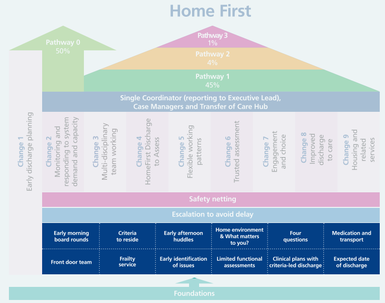


Figure 2:
Foundations of Home First / Discharge to Assess

Note: The percentages apply to people aged 65 years and over. The guidance applies to adults aged 18 years and over. When used across all adult age groups, it is expected that a higher percentage will be allocated to Pathways 0 and 1, and a lower percentage will be allocated to Pathways 2 and 3.

What a good hospital discharge looks like, continued



Foundations

Early morning board rounds – Every ward in an acute hospital should have an early morning board round attended by the multi-disciplinary team including consultant(s), doctors, nurses, therapists and discharge team representatives. Every person will be discussed, plans will be agreed, and actions assigned.

Criteria to reside – The criteria to reside (Annex A) should be used to help determine whether someone is ready for discharge.

Early afternoon huddles – Tasks allocated at the morning board round should be reviewed by the multi-disciplinary team in a 'huddle' to ensure all actions are on track.

Home environment – It is critical to capture information about a person coming into hospital from the earliest contact. If arriving by ambulance, the information gathered by the ambulance crew about home circumstances, carers, family, friends, access to the property, equipment already in situ, etc., should be captured from the beginning. The person's care record will follow them through their hospital stay and help to inform the safe transfer of care arrangements when they are ready to leave the hospital.

What matters to you? – When someone arrives in hospital they should always be asked "what matters to you?" and "how can we take account of that while you are in our care?". This is vital information for the care record and planning which must follow the person if they are admitted to an assessment unit or a ward. If they cannot answer for themselves then carers, family and/or friends should be asked. Some people may already have a personalised care and support plan or personal wellbeing plan in place which sets out their needs and preferences.

Four questions – The person and their carers, family and/or friends should be kept updated about the plan for their care, treatment and discharge throughout their hospital stay.

These four questions are a great way to test if this is happening:

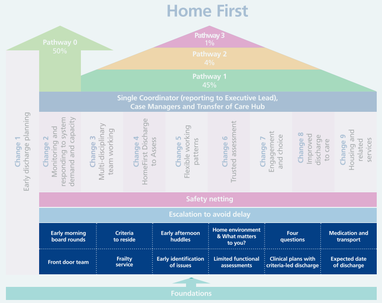
1. What do you understand about the main reason you are in hospital? What concerns you the most?

2. What do you understand about what is planned today and tomorrow to investigate and treat your symptoms? Is there anything you're not clear about?

3. Can you explain the things that need to happen for you to safely go home? Is there anything you're worried about? What support will you need to help you do these things?

4. When are you expecting to go home safely?

What a good hospital discharge looks like, continued



Medication – A person discharged from the emergency department should be provided with any medication prescribed within the emergency department and information about any further action they need to take (e.g. contact GP; return for outpatient appointment; return for diagnostic appointment, etc.). A person discharged from a ward should have their 'to take out' medication ordered in good time and delivered to the ward the day before discharge.

Transport – Having access to 24-hour on-call transport can help to stop inappropriate 'social' admissions and prevent delayed discharges. The choice of options for transport home should start with carers, family members, neighbours and friends. Voluntary sector 'take home and settle' services, taxis or public transport may be options. Hospital transport should only be used when necessary and after all other options have been exhausted. For those small numbers of people who do need a non-emergency patient transport service, this must be planned and coordinated with discharge plans and shared with the transport service before discharge.

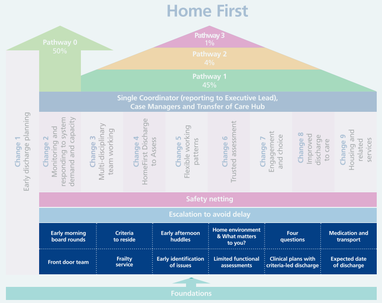
Front door team – All acute hospitals should establish a front of house multi-disciplinary team located in the emergency department working seven days per week. This would normally include nurses, occupational therapists, physiotherapists, some social care professionals and ideally health inclusion care co-ordinators. Having access to community-based services providing appropriate levels of care to people in their own homes should mean the team has access to:

- Urgent community response services, mental health crisis services and voluntary sector support services for people who do not require hospital admission and could be better supported by those services.
- Virtual ward services for people who require acute care and meet the virtual ward admission criteria.

Frailty service – A frailty service should gather information about a person and how they have been managing in the two weeks prior to admission. For people who may be frail, use of a recognised frailty tool, such as the Rockwood Clinical Frailty Scale, is good practice. The Acute Frailty Network hosted by NHS Elect supports people with frailty and urgent care needs to get home sooner and healthier.

Early identification of issues – On admission, early identification of any potential issues that might affect the discharge arrangements of an individual enables a plan to be implemented in good time.

What a good hospital discharge looks like, continued



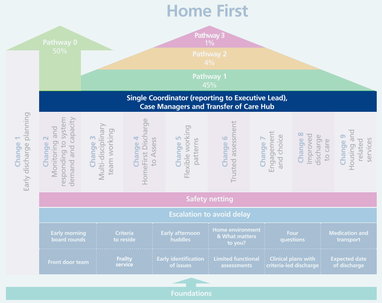
Limited functional assessments – Functional assessments should be enough to enable safe transfer from the hospital, prior to more detailed assessments at home. These should take place in good time to enable same-day discharge.

Clinical plans and criteria-led discharge – Every person should have a clinical plan, with an expected date of discharge, and clear criteria that must be met for discharge to be able to happen.

Expected date of discharge – Everyone who is admitted to hospital should be given information as soon as possible about the purpose of their admission and what will happen when their acute treatment is completed. This should include their expected date of discharge and information about how and when discharge from the hospital will occur. The SAFER patient flow bundle is a practical tool that can be used to reduce delays for patients in inpatient wards.

Escalation to avoid delay – A delayed discharge should be treated as a potential harm event. There should be a clear procedure to escalate any issues that are delaying a discharge through an agreed Executive Lead within the system. There should also be a clear, robust and workable communication system in place so professionals can share up to the minute information on patient needs.

What a good hospital discharge looks like, continued

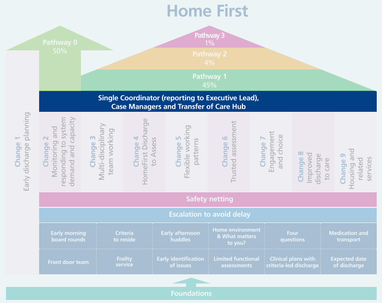


Key roles

Executive Lead – Every local health and social care system should identify an Executive Lead who should act on behalf of the whole system to provide strategic oversight of Discharge to Assess. The Executive Lead should have responsibility for ensuring good system governance and positive outcomes for people discharged from hospitals in their system. The Executive Lead may be employed at executive leadership level by any organisation in the system and can be from any relevant professional background. They should oversee a Single Coordinator who will report and escalate issues to them.

Single Coordinator – Every local health and social care system should have a Single Coordinator. This system leadership role should act on behalf of the whole system and work both strategically and operationally to ensure Discharge to Assess is a success. They should develop a shared system view of discharge, hold all parts of the system to account and drive the actions that need to be taken as a system to address shared challenges. The Single Coordinator may be employed by any organisation in the system and can be from any relevant professional background. They should report to a named Executive Lead.

What a good hospital discharge looks like, continued



Case Managers – Every person discharged on Pathways 1-3 should be allocated a Case Manager by the Transfer of Care Hub to aid and monitor the person's discharge and recovery. This operational role should liaise with relevant professionals to support the person's discharge and monitor progress against the goals outlined in their recovery and support plan, ensuring adjustments are made or the support is stopped if necessary. After a sufficient period of recovery, if it appears the person may need support on a long-term basis, the Case Manager should liaise with relevant professionals to ensure timely assessment of long-term care needs (they will not usually carry out these assessments themselves). In any one system there will be multiple Case Managers who may be employed by any organisation in the system and can be from any relevant professional background. A Case Manager may change throughout a person's journey depending on the person's needs and local set-up.

Transfer of Care Hub – Every local health and social care system should have a Transfer of Care Hub whereby (physically and/or virtually) all relevant services across sectors (e.g. healthcare, social care, hospice, housing, voluntary) are linked together to coordinate care and support for people who need it – to aid discharge and recovery and also admission avoidance (if this makes sense locally due to overlapping services and staff). For every person discharged on Pathways 1-3, the Hub will decide, in consultation with the person and their advocates, which Pathway they will be placed on based on the description of the person received from the acute ward, and will assign a Case Manager to each person. The Hub may be fully or partially co-located with acute settings, where suitable, and should operate seven days a week with local systems determining the hours of operation to ensure adequate coverage. Hub operations should be streamlined as much as possible.

Further information is available within staff action cards aimed at supporting different staff groups to implement Home First / Discharge to Assess – these are outlined in the 'Further resources' section at the end of this guide.

Case study

The Single Coordinator role

The North Cumbria local system have committed to the Single Coordinator role. The role is accountable to the system and has authority to operate at assistant director / associate director level within each of the organisations to make things happen. This has been really useful to develop a shared system view of discharge, hold all parts of the system to account and understand the actions that need to be taken as a system to address shared challenges. Sitting outside of the individual organisations means the role can genuinely represent a one system view.

Case study

Development of the Transfer of Care Hub function

East Suffolk and North Essex NHS Foundation Trust and Suffolk County Council have developed a Transfer of Care Hub (known locally as the Integrated Discharge Hub) to deliver the aspirations of the national discharge guidance. Prior to implementation of the Hub, existing health and social care teams managed different patients cohorts and followed different protocols which resulted in duplicate assessments and multiple hand-offs and delays.

The Hub has created a single point of access for all Discharge to Assess referrals with shared staff and systems across health and social care. This has resulted in streamlined processes across all teams. The shared staffing model has helped to build relationships by giving colleagues an insight into each other's roles and the challenges faced by colleagues in other organisations.

Shared access to systems has provided a much more detailed and accurate overview of the status of individuals. The management of more complex cases has benefitted from closer working and joined-up systems which facilitate joint problem solving and escalation.

In addition to performing an operational function, the Hub has helped strategic work. It has provided a clearer view of the nature of delayed discharges, supporting the collaborative commissioning of solutions. By providing greater visibility of Discharge to Assess Pathway performance, it has also helped guide the prioritisation of resources to achieve maximum benefit.

Discharge to Assess Pathways

As per the duty set out in the Health and Care Act 2022, NHS trusts and foundation trusts must involve patients and any carers (including young carers) in early discharge planning for those likely to require care and support following discharge from hospital. Under this duty, a carer is defined as an individual who provides or intends to provide care for an adult, otherwise than by virtue of a contract or as voluntary work.

Pathway 0

This is for simple discharges and should represent a minimum of 50% of people aged 65 years and over who are discharged from hospital. People on this Pathway will go straight home after their treatment in hospital is complete, to recuperate with normal access to their GP, or with some arranged follow-up, e.g. from a practice or community nurse. Pathway 0 is also for people who have a home care package that is active and unchanged at the point of discharge and continuing at the same level as that delivered prior to admission to hospital. Several systems have collaborated well to ensure this is the main Pathway out of hospital. In one system they have achieved 99% of people going home on Pathway 0 and Pathway 1 combined. Voluntary sector services, neighbourhood support, signposting to local service directories and/or social prescribing should also be considered and commissioned to support discharge and prevent further admissions to hospital. The needs of any carers should also be considered through a carers assessment where appropriate or through a referral to a voluntary sector carers support service.

Pathway 1

A minimum of 45% of people aged 65 years and over who are discharged from hospital will go home with some short-term reablement or other personalised community-based support to help with their recovery and care. Pathway 1 is also for people who have a home care package that is being restarted at the same level as that delivered prior to admission to hospital after lapsing during their hospital stay. Some people who temporarily need 24-hour nursing care at home may be able to be discharged on Pathway 1. A Case Manager will be allocated to every person on Pathways 1-3 to actively monitor their progress and engage appropriately with carers. The support package will be flexed to match the progress of the individual. During the recovery period, assessment of long-term needs and any financial assessments can be made by the relevant professional as soon as they decide that an accurate assessment of future needs is possible.

Discharge to Assess Pathways, continued

Pathway 2

A maximum of 4% of people aged 65 years and over who are discharged from hospital will need short term rehabilitation and potentially reablement in a community bedded facility or care home with therapeutic and nursing support to help with their recovery. The intention must still be to get the person back to their home (or usual place of residence) following the period of rehabilitation. The support package will be flexed to match the progress of the individual. Regular reviews of the person's progress should be made by the relevant professional to avoid any delay in the person's return home. It is possible that people being discharged home (after a period in a community bedded facility) will need a further period of reablement support at home. Where it is possible for the person to be discharged home, the needs of any carers should also be addressed through a carers assessment (both post discharge and at the end of the time-limited period) and potentially also through a referral to a voluntary sector carers support service.

Pathway 3

This is for people who require bed-based 24-hour care following discharge from hospital which will include people discharged to a care home for the first time (likely to be a maximum of 1% of people aged 65 years and over), plus existing care home residents returning to their residential or nursing care setting. The small number of people who are discharged to a care home for the first time will have such complex needs that they are likely to require 24-hour bedded care on an ongoing basis; these people should still be assessed for their long-term care needs in that context prior to a permanent care home placement being made if appropriate. During the recovery period, assessment of long-term needs and any financial assessments can be made by the relevant professional as soon as they decide that an accurate assessment of future needs is possible. No decision should be made to permanently place a person in a residential and/or nursing care home for the first time without first giving them an opportunity to recover then assessing them for their long-term care needs. The local authority and a social worker must be involved in any decision to discharge a person to a care home for the first time.

Virtual wards

Virtual wards are a safe and efficient alternative to NHS acute care that are enabled by technology. They support people who would otherwise be in hospital to receive the acute care, monitoring and treatment they need in their own home or usual place of residence. This includes allowing people to be cared for at home rather than be admitted to an acute hospital, or to go home sooner from an acute hospital.

In the context of hospital discharge, virtual wards are an alternative place of acute care rather than a discharge pathway as people on virtual wards remain under consultant-led care. However, onward discharge from virtual wards needs to be planned and may be via any of the discharge pathways (Pathways 0-3) as appropriate.

Case study

Prioritisation of Pathways 0 and 1

In the Swindon local system very low numbers of people are discharged on Pathway 3. Every person is given the opportunity to return home or to step-down into a temporary bed in the community to be assessed.

This has been achieved and the momentum maintained via a daily multi-disciplinary team call with all health and social care partners to agree every person's discharge and Pathway. The multi-disciplinary team discuss every person in the acute trust who has a planned discharge medical status for today, tomorrow or in the past to expedite discharge.

The success of this approach has been helped by a clear and agreed focus on the Home First principle, alongside clear partnership working and strong leadership from the Single Coordinator providing direction and strategy.

Case study

Collaborative working

Barnsley Hospital and Community Partners found that previous attempts to trial Discharge to Assess had not been successful. After reviewing lessons learned this lack of success was felt to be associated with a lack of collaborative working between teams. COVID-19 requirements compelled them to try again and they achieved a greater result this time with sustained improvement in outcomes.

To aid collaboration and implementation each Pathway was given a workstream lead as a key individual to implement and report back progress to project task and finish groups. A monthly steering group was set up to provide direction and guidance and report overall progress to a system-wide project group.

Passionate leadership, with staff across health and social care working as a single team, supported the development. The system recommends focusing on building in collaborative working from the beginning with a clear vision and aim statement agreed by all relevant teams. The agreed aim can then be broken down into individual team objectives to support the development of the local Discharge to Assess model.

Case study

Use of inpatient therapists to support discharge on Pathway 1

East Cheshire health and social care services have worked closely during the past twelve months to support a Discharge to Assess process and minimise length of stay for those who do not meet the criteria to reside in an acute hospital bed.

Inpatient therapists have taken on the Case Manager role for people discharged home on Pathway 1. This has aided faster assessment and flow and, where reablement care is readily available, it prevents long length of stay and supports people to recover at home. This has reduced duplication, handoffs and streamlined the assessment process ensuring the right care is received in the right place following the Home First approach. Working collaboratively with both Adult Social Care and Brokerage has had a positive impact and resulted in a reduction in reliance on using community beds inappropriately.

Case study

Use of domiciliary care bridging service to support discharge

The Mid and South Essex NHS Foundation Trust (MSEFT) Bridging Service provides short-term domiciliary care for patients following discharge from an acute hospital, a community bedded setting or for admission avoidance, up until the point reablement/ domiciliary care provider can start.

By enabling same-day discharge, the service ensures each patient has access to the right care, in the right place, at the right time with the added benefits of increasing hospital bed capacity, improving flow, and reducing delayed transfers of care. In addition, this provision also encourages patient-centred care with an enablement approach that supports independence and avoids unnecessary readmissions.

Bridging supports discharges from all acute sites and community hospitals within Mid and South Essex, and supports admission avoidance in Basildon and Brentwood, Mid Essex and Castle Point and Rochford CCGs.

The service works closely with partners across health, social care and the voluntary sector including MSE Integrated Discharge Teams (IDT), Adult Social Care, CCGs, Urgent Community Response Teams (UCRT), Essex Cares Limited, British Red Cross, etc.

Strong collaborative relationships have been developed between MSEFT and Adult Social Care: to support the seamless transition of care to onward providers in line with their needs; to enable capacity to be flexed across Mid and South Essex on a daily basis in response to demand; and to allow for patients to be accepted into the service without formalised exit plans, given system awareness of the importance to source onward care quickly and maintain flow within the service.

Headline numbers:

- >3700 patients discharged into MSEFT Bridging Service between April 2020-March 2021
- Saving >13,000 bed days
- Low re-admission rate = <3%

Case study

Use of a local Healthwatch to support discharge

Brighton and Hove Healthwatch established the Hospital Discharge Wellbeing Project early in April 2020 as part of the response to the pandemic. This project is jointly funded by the local authority and CCG with oversight from the acute trust.

People discharged home on Pathways 0 and 1 are phoned by Healthwatch-trained volunteers within a few days of discharge from hospital, usually in the first week. The role of the volunteers is to signpost and assist people to find the help they need. As part of this the volunteers ask people if there are any outstanding issues associated with their hospital discharge, or issues that have arisen since coming home from hospital, previously unanticipated, with which they may need assistance.

Since the start of the project more than 2,500 people have been referred to the service and approximately 60% have been actively supported with 98.5% providing positive feedback on the service.

How to implement good hospital discharge

How to implement good hospital discharge

This section is for systems choosing to adopt a Discharge to Assess model, where affordable within existing local budgets. It should be read in conjunction with the Top Tips for Home First / Discharge to Assess. Staff action cards are available to support different staff groups to implement Home First / Discharge to Assess. Patient leaflets are available to support staff to communicate and engage with people regarding their discharge. Further information on both these resources is provided in the 'Further resources' section at the end of this guide.

Stage One: Before discharge

- Discharge planning should begin at, or before, admission, with early multidisciplinary team engagement. An expected date of discharge should be set prior to admission for elective admissions and within two days of emergency admissions. The expected date of discharge should be discussed and agreed with the person and their family members/ carers and reviewed throughout their hospital stay.
- From the outset, people should be asked who they wish to be involved and/or informed in discussions and decisions about their hospital discharge, and appropriate consent received. This may include a person's family members (including their next of kin), friends or neighbours, some of whom would be considered unpaid carers. Paid care workers and personal assistants may also be included. The person or people identified at this stage, including any unpaid carers, may be wider than a person's next of kin. A person who does not have family or friends to help, or who may find it difficult to understand, communicate or speak up, should be informed of their right to an independent advocate.
- Patients and any unpaid carers (including young carers) must be involved in early discharge planning conversations, where appropriate, as per the duty set out in the Health and Care Act 2022. It is essential to identify if there are any children in the household who may be impacted by a discharge home. A patient leaflet is available to support conversations on admission (see the 'Further resources' section at the end of this guide). The involvement of any providers of post-discharge recovery and support services, once known, will also help to ensure a smooth discharge process.
- Details about a person's home situation should be collected on admission. If further home assessment is needed this should be done with health and social care working in partnership and in good time. A trusted assessment may be helpful here.
- Some people may already have a personalised care and support plan or personal wellbeing plan in place and/or a personal health budget, personal budget or integrated personal budget. This should be checked and, where present, used to inform discharge planning.
- Some people (not all) may be selected for criteria-led discharge with most suitable fitting into Pathways 0 or 1. For those selected, clear clinical criteria for safe discharge should be documented that can be enacted by an appropriate junior doctor, nurse or allied health professional without further consultant review.
- There should be twice daily multi-disciplinary team reviews of all people in acute beds, including at the early morning board round a clinically-led review to identify people who no longer meet the criteria to reside in acute settings (see Annex A). There should be consistency of process, personnel and documentation in ward and board rounds.
- If discharging someone to a care home or hospice a COVID-19 test should be undertaken prior to discharge as outlined in the latest Government guidance: Infection prevention and control in adult social care: COVID-19 supplement and Coronavirus (COVID-19) testing for hospices.

How to implement good hospital discharge, continued

Stage Two: During and after discharge

- Everyone should work towards the expected date of discharge. People should be made aware of the discharge pathway decision and provided with the relevant patient leaflet depending on whether they are being discharged home or to another place of care (see the 'Further resources' section at the end of this guide).
- Systems may choose to offer a one-off personal health budget to those on Pathways 0 and 1 when payment for a good or service would enable early and safe discharge. This may be utilised when a good or service cannot be provided via existing commissioned services or cannot be provided in a timely manner; in addition, the good or service cannot be provided through unpaid care or the voluntary sector, or cannot be provided by them without this additional support.
- Those on all Pathways should be provided with any necessary support upon reaching their destination. As this is likely to have been drawn up without a full assessment, the support is also likely to change as the person's needs in this new environment become clearer.
- Those on Pathway 0 may not need any additional support other than that provided by their pre-existing support network. There will be some who will need linking into additional community support either from the voluntary sector, 1st or 2nd tier councils, etc. The ward staff will arrange their discharge and links to such services.
- Those on Pathways 1-3 will have their discharge managed by the Transfer of Care Hub and be allocated a Case Manager.
- A designated discharge area (if present and suitable) may enable prompt transfer out of a ward/unit and can be useful for people awaiting transportation, medication or confirmation of timing of the initial safety and welfare check/assessment. 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. For those on Pathway 0, evening discharges may sometimes be necessary, e.g. if a person's family members/carers are only able to collect the person in the evening. For those on Pathways 1-3, the timing of discharge often needs to be coordinated with whoever will be doing the initial safety and welfare check/assessment.
- Those on Pathways 1 and 2, and to some extent 3, should have a post-discharge recovery and support plan outlining the short-term reablement and/or rehabilitation that will be provided, alongside time-dated goals, supported by, or as part of, a personalised care and support plan or personal wellbeing plan. This will ensure they reach their optimum level of independence in as short a time as possible, e.g., manage stairs with aids, go shopping or make an internet order, wash independently, make a meal or snack, make a hot drink, keep in touch with people perhaps via social media, link to community support networks (social capital), etc.

How to implement good hospital discharge, continued

- The plan should be devised with the person and whoever they want to be involved, following a shared decision-making approach. It should focus on the areas that matter most to the person and may include supported-self management elements, taking into consideration their level of health literacy
- Ideally the plan will be overseen by a therapist (occupational therapist or physiotherapist). This does not mean a therapist must see every person, but one should discuss every plan at virtual ward rounds.
- Care workers, working as part of a reablement team will need different skills to that of mainstream care workers. Helping someone do something for themselves is a different task to doing something for someone. Investing in this specialist resource through direct employment may offer benefits over the use of agency staff to deliver these services.
- Experience shows us that the level of support provided under most post-discharge recovery and support plans reduces over a short time period although it may fluctuate in the early stages.
- Intervention should be flexible according to need.

How to implement good hospital discharge, continued

Stage Three: After reablement and/or rehabilitation

- Once people have reached their optimum level of independence, they may be able to return to living with their pre-existing support but may need help re-engaging with this. Following any rehabilitation there should be a clinical review and determination that the person has reached their rehabilitation goals and are at their optimum.
- Those with new long-term or ongoing care and support needs may be assessed via an NHS CHC assessment and/or Care Act 2014 assessment. Where appropriate, unpaid carers (including young carers) should be offered a carer's assessment as soon as practicable before caring responsibilities begin.
- A number of people will need ongoing support, possibly from the local authority or health. This transition should be seamless as the local authority should be involved before this point. In any event, a hand-off would not be helpful here. It is worth thinking that whilst an assessment of long-term care needs cannot be completed until a person's therapy-led post-discharge recovery and support plan is completed, the assessment can and should be started and information gathered. Those delivering the plan will be best placed to do this and it is another part of the process where a trusted assessment agreement could well be useful. A joint health and social care assessment (if NHS CHC is being considered) will avoid another time-costly handoff.
- Longer-term support may be provided by way of a personal health budget (NHS-funded), personal budget (local authority-funded) or integrated personal budget (both funding sources). It could be used to fund traditional support or a creative bespoke solution. For example, personal assistants (paid care and support workers) may be employed to help people in their own homes, allowing the person being cared for to decide who will support them and how, rather than support being provided by an agency.
- For systems implementing a Discharge to Assess model (best practice), Care Act (2014) assessments of adult social care needs and subsequent eligibility determinations should not take place in hospital. This allows for most of the adult social care resource based in hospital to be a part of the Discharge to Assess service.
- If implementing Discharge to Assess, there will still be a need for some social work presence on acute sites. Ideally a senior registered social worker will be embedded to ensure good communication and relationships are maintained. They will also investigate any safeguarding concerns and support with deprivation of liberty discussions or other complex matters.

How to implement good hospital discharge, continued

- Following a Care Act (2014) and associated financial assessment a person may have to pay for some or all of their subsequent care and this should not come as a surprise. As a result, reablement staff need to pass on this information and be able to answer basic questions about charging.
- On occasion a person may return for a second period of support via the Discharge to Assess service, but this will not normally be the case unless it is after a new hospital admission.

Definitions of reablement and rehabilitation

These definitions are simplified from the NICE and NHS Data Model Dictionary definitions of intermediate care.

Reablement services

These are community-based services, typically provided by a multi-disciplinary team involving social care practitioners to people in their own home (or usual place of residence). They involve assessments and interventions aimed at maximising independent living by helping people to regain the skills and confidence they need to do things for themselves. Reablement services can be used to support hospital discharge and subsequent recovery or admission avoidance, e.g. via the Community health services two-hour urgent community response standard.

Rehabilitation services

These can be broadly divided into non-specialist rehabilitation services (covered by this document) and specialist rehabilitation services (provided to people with complex needs following severe illness or trauma, e.g. stroke or neurological injury). Non-specialist rehabilitation services are typically provided by a multi-disciplinary team involving therapists to people in their own home (or usual place of residence) or bed-based setting. They involve assessments and interventions aimed at supporting timely discharge from hospital, aiding recovery from illness, preventing unnecessary acute hospital admissions and preventing premature admissions to long-term care.

Safety netting

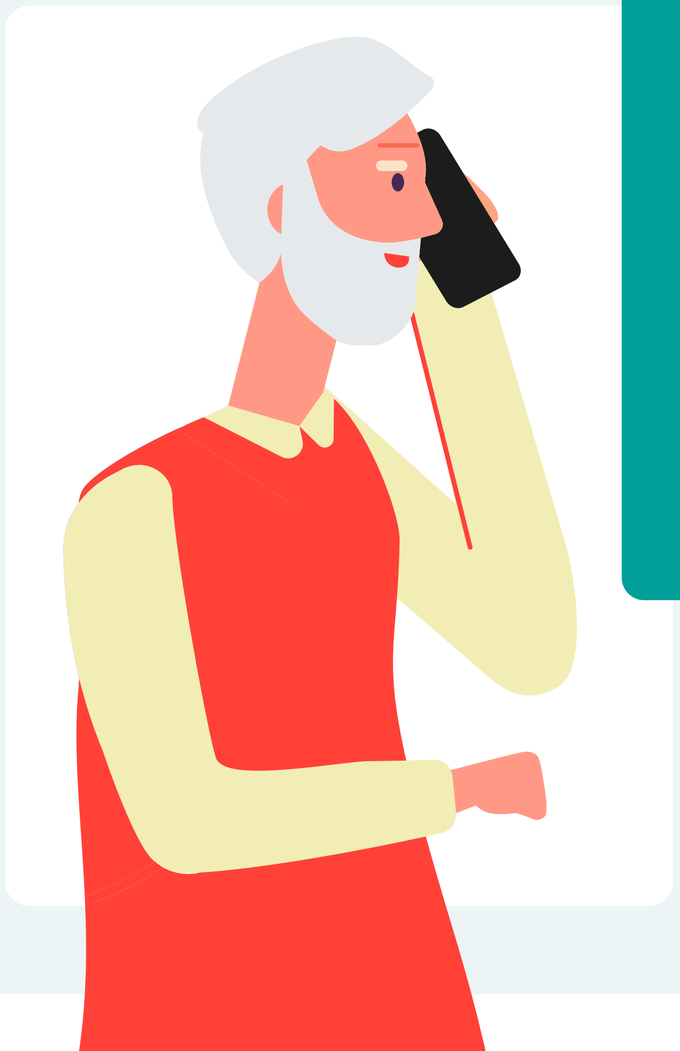
Safety netting in relation to hospital discharge is the process through which people are given advice on discharge and monitored and followed-up after they have been discharged.

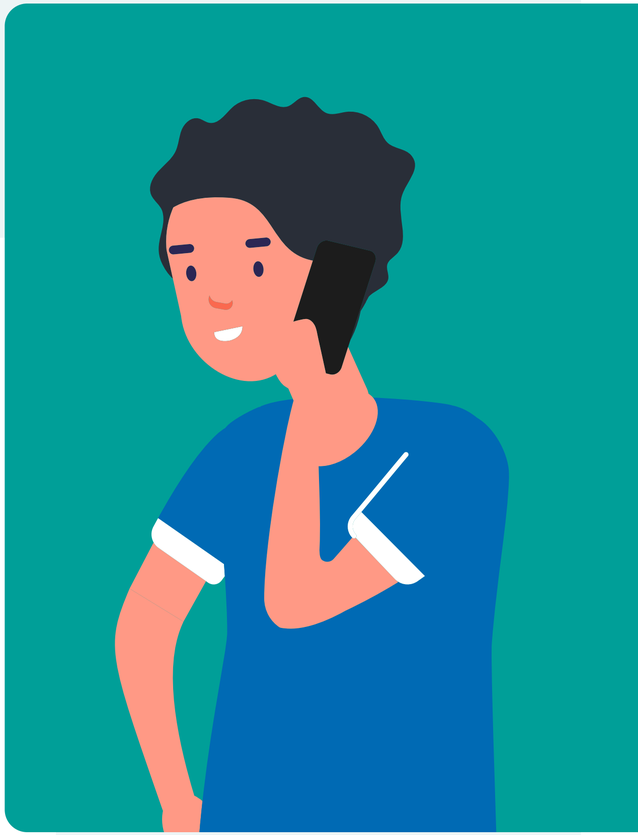
The preferred method is patient-initiated follow-up where a person is given the contact details of their discharge team at the point of discharge and advised to make contact if they are concerned about anything. This should include advice relevant to the specific circumstances of the individual.

The key principles of safety netting are good communication, maintaining continuity of care and minimising handoffs. As such people should not be asked to see their GP or go to the emergency department following discharge and they should not be followed up by a new team unless this is an agreed process with a good handoff.

A hospital discharge safety netting matrix is provided at Figure 3. This is to help clinicians and members of the discharge team make balanced decisions to support safe discharge.

Please note, transfer of care from an acute hospital to a virtual ward should only be considered where a patient meets the criteria to reside and acute-level care can be provided by a virtual ward team. Virtual wards should not be used to support safety netting – appropriate use of the discharge pathways should be considered.





Safety netting, continued

Figure 3: Safety net matrix

Situation	Consider	Do not
Person is low risk.	Giving person contact details of discharge team and advising them to make contact if they are concerned (i.e. patient-initiated follow up). Directing person to local directories of support organisations (e.g. voluntary sector) and digital or hard copy resources (e.g. on self-care).	Advise person to see their GP or go to the emergency department following discharge. Arrange routine outpatient appointments.
Person lacks confidence about how they will cope post-discharge.	Scheduling a telephone call with person a day or so after discharge to check all is well and provide reassurance. Directing person to local directories of support organisations (e.g. voluntary sector) and digital or hard copy resources (e.g. on self-care).	Extend person's acute hospital stay. Advise person to see their GP or go to the emergency department following discharge. Arrange routine outpatient appointments.
Person is awaiting results of investigations.	Calling the person to convey the results once available and discuss any change in management that may be required. This call can be made by discharge team or by a community or voluntary team if care is handed over to them.	Ask person's GP or other team (unless there is a clear handover) to chase and act on results.
Person needs a review at a certain time, e.g. for a wound check, trial without a catheter or removal of a drain.	Bringing back the person electively as a ward attender to the same ward or a community clinic. Timescales should be communicated to community teams.	Advise person to go to the emergency department or outpatient clinic to be seen by a new team for review.

Information sharing

Under Discharge to Assess, limited assessments are undertaken in hospital settings as people requiring ongoing care and support (Pathways 1-3) should undergo assessments of their short-term care needs soon after discharge to inform a post-discharge recovery and support plan outlining the reablement and/or rehabilitation that will be provided to aid their recovery alongside personal time-dated goals for improvement. An initial safety and welfare check/assessment should be undertaken on the day of discharge to ensure basic safety and care needs are met and allow time for a fuller assessment to take place as the persons settles.

Discharge planning should start at the point of admission for the early identification of care and support needs. Conversations should involve the person and their carers, family and/or friends (where appropriate), as well as local care providers (e.g. care home, home care and hospice) if necessary. Patients and any unpaid carers (including young carers) must be involved in discharge planning conversations, where appropriate, as per the duty set out in the Health and Care Act 2022. Planning should consider the resources and services required to support a safe and timely discharge, including the interim care and support the person needs prior to relevant assessments being carried out.

The hospital should provide sufficient and accurate information to enable any providers of onward care to meet the needs of the person transferred to them including details about the person's condition, information about the person's medications, any safety netting arrangements, whether an existing personalised care and support plan or personal wellbeing plan has been updated or developed, and contact details in case there is an issue or concern following discharge.

For people on all discharge Pathways (Pathways 0-3), a discharge summary should be sent by the hospital to the person's GP on discharge as set out in the 2022/23 NHS Standard Contract. Best practice is also to share the discharge summary with the person on discharge. The Royal College of Physicians has produced learning resource materials on improving discharge summaries.

Support for discharge

Trusted assessments and trusted assessors

Trusted assessments speed up process delays caused by the lack of availability of usual assessors. Care should always be taken to check that a change in the process or tool is not an easier way to reduce the delay, e.g. a re-designed process removing off-site assessment sign-off or a shortened assessment form.

A trusted assessment may be:

1 An assessment carried out by a trusted assessor

A trusted assessor is a person employed to carry out an assessment when the usual assessor is unable to do so in a timely manner. The most common deployment of trusted assessors has been when a decision has been made that a person needs to move to residential care, but the home manager cannot come into hospital to carry out their assessment the same day. Trusted assessors can be used in a lot more areas than this and systems are encouraged to widen the scope and use them to reduce process delays in other areas. This is because very few people should be leaving hospital to go into residential care and a higher impact may be achieved in other areas.

2 An assessment originally designed for one purpose that is used for a second purpose

This would need to be by agreement in advance, i.e. the assessor would be aware of the arrangement and may have had to slightly amend their assessment to ensure it serves both purposes. An example could be an assessment carried out on the ward by an occupational therapist that is also used to allow a person to transfer to a Discharge to Assess service and inform the initial support provided.

Support for discharge, continued

Carers

Any unpaid carers (including young carers) must be involved in discharge planning conversations, where appropriate, as per the duty set out in the Health and Care Act 2022. Discussions should cover how much care they are willing and able to provide and ensure they have their own carer's assessment where there is an indication of need. They should be linked to local resources and support from local carers networks and/or other organisations.

Voluntary, community and social enterprise sector and NHS volunteers

The voluntary, community and social enterprise sector has a wide range of highly responsive services to support people leaving hospital and their carers. Many NHS providers engage volunteers to support the discharge process, from helping reticent people feel more comfortable about going home, to supporting multi-disciplinary teams with discharge planning and coordination. Trust-based 'take home and settle' schemes can support transport home and offer additional follow-up support to reduce readmissions. People should always have the option and be linked with voluntary services at the point of discharge.

Many health and social care systems have seen people benefit from services such as 'take home and settle', services to alleviate loneliness, handyperson support, community transport schemes and many more. Local and national voluntary sector organisations can be valuable partners in providing flexible support which offers good value for money.

Case study

Use of the voluntary sector to support discharge – British Red Cross

The London region have established a programme of support delivered by the British Red Cross (BRC) to enable facilitated discharge on Pathway 0 across the region. The BRC coordinates with other voluntary sector organisations to provide ongoing and sustainable support in the community. This includes a range of services such as transport, settling-in support and the provision of necessities. This helps to minimise delays to discharge for non-clinical reasons, support patient flow and decrease the risk of people being unnecessarily readmitted.

Since the pandemic, additional resettlement support has been incorporated into the programme and a flexible service model has been adopted to meet the varying needs within hospitals and the community.

Support for discharge, continued

Telehealth and telecare

Telehealth describes devices that automatically send health monitoring results to a GP or consultant for remote monitoring of vital signs such as blood glucose, blood pressure or oxygen levels.

Telecare describes standalone devices or alarms linked to centralised call centre response teams e.g. falls detectors, pendant alarms, medication reminders and voice activated devices. These should always be considered as an adjunct to other discharge support. Consideration of these devices can make the difference between someone going home on Pathway 0 or on other Pathways and should always be included as a section on the discharge summary/ transfer of care form.

This is supported by the NHS@home programme which seeks to provide enhanced NHS services, utilising the best technologies available to enable personalised clinical support to be delivered virtually to people in the setting of their own home (or usual place of residence). It aims to ensure people have faster access to more appropriate and targeted care, without necessarily having to attend emergency care or arrange GP appointments.

Case study

Use of telecare to support discharge

The Hampshire local system provide support to people at home following hospital discharge using standalone mobile devices incorporating an SOS button dispensed by NHS acute staff or local authority reablement teams at the point of discharge or immediately thereafter. The devices link with monitoring centres enabling a person to return and remain at home safely prior to a full specialist care technology assessment taking place in their home. Partnership working with short-term domiciliary care providers enables them to refer for long-term packages of care technology, thus reducing bureaucracy and minimising delays for longer-term support.

Personalised care

Personalised care means people have choice and control over the way their care is planned and delivered, based on 'what matters' to them and their individual strengths, needs and preferences. This happens within a system that supports people to stay well for longer and makes the most of the expertise, capacity and potential of people, families and communities in delivering better health and wellbeing outcomes and experiences.

The following six evidence-based components of the comprehensive model for personalised care will support and enable systems designing, implementing and embedding Home First / Discharge to Assess core principles to achieve better outcomes for people and the wider system.

1. Shared decision making

Shared decision making ensures that individuals are supported to make decisions that are right for them. It is a collaborative process through which a clinician supports a patient to reach a decision about their treatment. The conversation brings together:

- The clinician's expertise, such as treatment options, evidence, risks and benefits.
- What the patient knows best: their preferences, personal circumstances, goals, values and beliefs.

2. Personalised care and support planning

Personalised care and support planning is central to achieving the optimal support for people who require post-discharge recovery and support services. It is an essential tool to ensure there is one joined-up post-discharge recovery and support plan that covers the person's health and wellbeing needs. A person may already have an established personalised care and support plan which acute and discharge staff should access when considering care options.

3. Patient choice

The NHS choice framework sets out people's rights to choice about their health care, where they can find information to help them make a choice, and how they can complain if they have not been offered choice. Information about patient choice as it applies to hospital discharge and post-discharge recovery services is provided in the Hospital discharge and community support guidance.

4. Social prescribing

Social prescribing and community-based support is an effective way of supporting discharge and preventing unnecessary hospital admission, through connecting people into their community and wider support via link workers who are based in primary care networks. Link workers support people who are affected by the social determinants of health (such as unemployment or loneliness), low level mental health problems and/or long-term conditions which affect their health and wellbeing. They take a holistic approach to people's health and wellbeing, starting with what matters to them and can help people to connect to voluntary sector support and community groups as well as local directories and self-care resources.

Personalised care, continued

5. Supported self-management

Supported self-management is a way that health and care services can encourage, support and empower people to manage their ongoing physical and mental health conditions themselves. There are additional roles as part of the primary care network team using supported self-management approaches to support people in the community:

- Care Coordinators play an important role within a primary care network to proactively identify and work with people, including the frail/elderly and those with long-term conditions, to provide coordination and navigation of care and support across health and care services.
- Health Coaches use their skills to coach and motivate people over a period of sessions to self-identify their needs, set goals and improve their knowledge, confidence and skills.

6. Personal health budgets, health budgets and integrated personal budgets

Personal health budgets (funded wholly by the NHS), personal budgets (funded wholly by the local authority) and integrated personal budgets (funded by both funding sources) are a method of providing care and support that can be more flexible than traditionally commissioned services. Therefore, they are an important offer for people who have ongoing care and support needs once they have reached their optimum level of recovery following discharge. They give greater flexibility and increased choice for people who are eligible and should be considered and offered to a wide range of people who require health and/or social care. These budgets can be directly commissioned by the NHS and/or local authority, operated through a third-party organisation, or the person may fully self-direct their care, using a direct payment.

People who have been assessed as eligible for NHS CHC have a legal right to have a personal health budget, along with some other specific groups, such as people eligible for aftercare services under s117 of the Mental Health Act 1983.

Systems may choose to offer a one-off personal health budget to those on Pathways 0 and 1 when payment for a good or service would enable early and safe discharge. This may be utilised when a good or service cannot be provided via existing commissioned services or cannot be provided in a timely manner; in addition, the good or service cannot be provided through unpaid care or the voluntary sector, or cannot be provided by them without this additional support.

Considerations for specific groups

People who are homeless or at risk of homelessness

Meeting the needs of people who are homeless or at risk of homelessness is often felt to be an intractable problem, which can result in discharges being delayed and people not getting the right services to help with their recovery and housing following discharge. The multiple and complex needs of some homeless people along with their unsettled status means that securing appropriate housing and support services can take time. In addition, preventing discharge that is too early is often an issue for this group.

NHS trusts have a statutory duty under the Homelessness Reduction Act (2017) to refer people who are homeless or at risk of homelessness to a local housing authority. Guidance and resources to support NHS trusts and other public authorities to meet this duty has been produced by the DLUHC and MHCLG. This includes a health services checklist, referral form and local authority contact details. The High Impact Change Model to support timely hospital discharge also includes guidance on hospital discharge and housing and related services (as part of Change 9) and an accompanying support tool is available. Further information can also be found in a briefing on positive practice of adult safeguarding and homelessness.

It is important to be aware that homelessness potentially can be linked to early ageing and high levels of frailty and other issues such as self-neglect. This means the involvement of adult social care alongside housing and health will often be key to improving outcomes through the Discharge to Assess process.

Case study

Specialist Discharge to Assess reablement for people who are homeless

Cornwall Council working in partnership with Harbour Housing and Stay at Home have redesigned their out of hospital care services to increase the number of options available to homeless patients leaving hospital on Discharge to Assess Pathways.

For those patients who do not have a home and require more than just a signposting service, Harbour Housing provides access to six self-contained units of accessible step-down accommodation. This comes with onsite practical support such as helping people to get to their hospital appointments, as well as holistic 'enrichment support' for improved health and wellbeing including counselling and a range of strengths-based activities. Where people have care and support needs including self-neglect and issues linked to drug and alcohol use, a specialist reablement service is provided for a time-limited period.

The Stay at Home service provides CQC regulated activities into the step-down accommodation and into the community. Specialist reablement workers are trained in the use of trauma-informed approaches and can, for example, deliver Naloxone to prevent drug related deaths from overdose. During the reablement period, permanent housing is arranged and where necessary a Care Act (2014) assessment is carried out to identify needs for any longer-term care and support.

Before these specialist Discharge to Assess services were in place homeless patients would usually have stayed in hospital for long periods (sometimes up to six weeks) while waiting for various care and housing assessments to be completed.

Considerations for specific groups, continued

People who may lack mental capacity or need safeguarding

Supporting people's choices, discussing risk with them and being alert to possible safeguarding concerns is essential to discharge on all Pathways.

The Mental Capacity Act (2005) protects and empowers people who may lack the mental capacity to make their own decisions about their care and treatment. If there is a reason to believe a person may lack the relevant mental capacity to make their own decisions about their care and treatment, a capacity assessment should be carried out before a decision about their discharge is made. Where the person is assessed to lack the relevant mental capacity to make a specific decision, there should be a 'best interest' decision made for their ongoing care. If the proposed arrangements amount to a deprivation of liberty, Deprivation of Liberty Safeguards (DoLS) for care homes arrangements and orders from the Court of Protection for community arrangements apply. To minimise any delay to discharge, this should be commenced as early as possible.

Further information can be in guidance on the Mental Capacity Act (2005) and DoLS during the COVID-19 pandemic.

Where staff have concerns about someone's physical or mental health and wellbeing as a result of a poor discharge, appropriate safeguarding advice should be sought. Further information on Safeguarding Adults is available.

People receiving palliative or end of life care

People who have palliative or end of life care needs, but are not imminently dying, may be discharged on any of the discharge pathways. If implementing Discharge to Assess, those who need it should receive a short period of care and support, including reablement and/or rehabilitation, to help them recover, as much as possible, from the incident which led to their hospital stay. Their personalised care and support plan, including any advance care plan, will help to guide their care. This is an important opportunity to help them review and update their advance care plan if they wish, or to initiate advance care planning conversations if one does not already exist. These conversations should be continued after discharge if not already completed.

People with a rapidly deteriorating condition that may be entering a terminal phase may require 'fast-tracking' for the immediate provision of NHS CHC utilising the NHS CHC Fast Track Pathway Tool and National Framework. People in the last days or hours of their life should have their needs met in line with the five priorities for care outlined in One Chance To Get It Right. If a person has an advance care plan and is unable to participate in decision-making, their preferences and priorities as documented must be taken into account. Those who are important to them must be consulted and their views taken into consideration.

People with no recourse to public funds

Further consideration should be given to securing safe discharge for those with 'no recourse to public funds'. Each case should be considered on an individual basis and may require expert advice and involvement from the Home Office and immigration officials. The legal and regulatory framework in this area is complex and the local authority and Integrated Care Board will need to carefully consider an individual's rights in these circumstances. Expert advice can be accessed through the No Recourse to Public Funds Network which has regional networks across the country.

Case study

Discharge for people receiving palliative or end of life care

The Isle of Wight Integrated Discharge Team (IDT) links closely with the Integrated Palliative and End of Life Team (IPET) to ensure the principles of Home First and Discharge to Assess are fully embedded across palliative and end of life care services. The ethos and vision of IPET remains at the core: to ensure forward care planning occurs with the person and people important to them and ensure they experience high quality end of life care.

IPET work in partnership with Mountbatten Hospice who provide not only bed-backed hospice support, but also outreach care at home and dedicated 24-hr support for families. They also work with domiciliary care providers and residential and nursing homes. This ensures people have a timely and responsive provision whilst retaining the opportunity to have their care provided where they choose and with the continuity of existing support arrangements, augmented with expert advice and support.

Considerations for specific groups, continued

People being discharged to a care home (including COVID-19 testing)

Information essential to the continued delivery of care and support to a person following discharge must be communicated and transferred to relevant heath and care partners, including care homes.

People returning to their care home where they lived prior to admission to hospital, or transferring to a care home for the first time, should be discharged on Pathway 3. Those transferring to a care home for the first time should represent less than 1% of all people aged 65 years and over discharged. These people are likely to require 24-hour bedded care on an ongoing basis, however they should still be assessed for their long-term care needs in that context prior to a permanent care home placement being made if appropriate. No one should be discharged to a care home for the first time without local authority involvement.

For the latest information on COVID-19 testing and self-isolation requirements for people discharged from hospitals to care homes, please consult the latest Government guidance: Infection prevention and control in adult social care settings and Infection prevention and control in adult social care: COVID-19 supplement.

Measurement to support system improvement

Measurement to support system improvement

For systems choosing to adopt a Discharge to Assess model

Arranging timely personalised discharge from hospital is a complex process that requires coordination, planning and communication across multiple players working in different organisations. This guide sets out how this can be achieved, but it is local systems that must make it work in their own contexts. By understanding how well the system is delivering each step of the individual's journey through the acute treatment, recovery and assessment phases, it is possible to effectively fix problems together and improve the experience and outcomes for each person in your care.

Measurement to support system improvement, continued

Criteria to reside

This is a checklist of reasons why someone would need to be in an acute hospital (see Annex A). It is a useful tool for clinicians to use when considering whether someone still needs acute care, particularly during the daily board round discussions. If they don't meet the criteria to reside in an acute hospital bed they should leave without delay.

These are 'minimal' criteria which can be challenged, and boundaries pushed to minimise the stay even further and thus be used as an improvement tool. Having this clarity about the purpose and benefit of being in an acute hospital helps to expose other shortcomings and opportunities for improvement. If someone remains in the hospital, despite clearly not meeting the criteria to reside, the reasons need to be clearly identified and actions taken by the system to remove the delay. These are often process, logistical or service supply issues about which systems can take rapid action. System leaders should develop channels where issues such as this can be raised and improvements put in place.

To allow the system to take appropriate action, the quality of the data must be accurate and reliable. Accurate data inputted about the reasons to reside can only come from senior clinical leadership attending the board round or ward rounds, seven days a week. The clinical decision and the reasons for it should be captured in real-time during the morning board rounds either by clerical support or by using adaptations to the patient flow dashboards which most trusts already have.

Data collection

Table 1 on the next page includes data that is already being collected and some data that will be collected in the future. This will enable local systems to assess how well they are performing at each step and take action to improve wherever and whenever necessary.

It is essential that systems enable access to high-level data from each other to facilitate shared analysis and intelligence which can lead to effective system-owned actions.

Using a process of time and date stamping can be a useful way to maintain 'quality control' across the Pathway. It provides insight into person level journeys and protects person identifiable data. Using a series of checkpoints, the Pathway can be broken into different stages. The time difference between each stage provides information into how the system is operating at any point in time (see Table 1). There are some important outcomes related to each stage and these are displayed in bold at the relevant stage in the Pathway.

With regards to monitoring demand and capacity, daily, out of hospital Situation Reports, clearly setting out community health and social care capacity, must be stored centrally so easily accessible by discharge team members (e.g. for daily bed meetings) and all others involved in facilitating timely discharge, with staff members nominated for making regular Situation Report daily updates. This should include an efficient method of enabling timely inputting of bed capacity data from across the system, with robust, regular data feeds established with all relevant out of hospital services.

Table 1: System flow measures

Pathways 1 - 3		Responsible Org.[n]	
No.	Descriptor	Acute	Community Health or Social Care
1a	Admission to acute	✓	
2a	Does not meet the 'criteria to reside'	✓	
2b	Identification of time lag between 2a and 3a	✓	
2c	Identification of reason person remains in hospital	✓	✓
3a	Time referral sent to the Transfer of Care Hub	✓	
3b	Proportion of people assigned to each Pathway by the Transfer of Care Hub		✓
4a	Discharged	✓	
4b	% of people discharged to the usual place of residence (UPR)	✓	
5a	Time person left hospital	✓	✓
5b	Length of Stay on discharge	✓	
6	Assessment and initial care completed within timeframe agreed with person		✓
7a	Number of interventions in the time-limited recovery period		✓
7b	Date discharged from, up to the end of the time-limited recovery period		✓
7c	Adult Social Care Outcomes Framework – proportion of people discharged with no or lower care needs after the time-limited recovery period		✓
8	Number of people who have been discharged from hospital who are still at home 90 days later or have had a planned death at home post-discharge		✓
9	Readmissions within 30 days or seven days or both	✓	
10	User experience and satisfaction data on the discharge process	✓	✓

Measurement to support system improvement, continued

Capacity and demand management

Systems will need to work across organisational boundaries to support capacity and demand management and identify the level of bedded and non-bedded community capacity that is required to improve recovery post-discharge, improve flow, and reduce the number of bed days lost in acute or community hospitals as a result of delays. Capacity and demand plans for intermediate care (covering admissions avoidance and discharge) are being agreed for the second half of 2022/23. These conversations at local authority level should support system level conversations.

In addition to local data on capacity, a national Discharge Pathways Analytical Tool is available to help systems better understand the needs of their local population and the Pathway 1 and Pathway 2 capacity required. They can use the tool to benchmark themselves against peers, to model scenarios to estimate the capacity required, and to forecast and forward plan to commission the right capacity for their populations throughout the year including during surge periods. Data reflected within the tool is drawn from multiple sources and should be validated and supplemented with local data, and form part of conversations to deliver joint planning and commissioning of services.

Experience measures

Understanding a person's experience of hospital discharge and post-discharge care can be obtained by triangulating information from a variety of sources nationally and locally, e.g. from the national CQC Adult Inpatient Survey (undertaken annually), and local incident reports, Friends and Family Test results and complaints information. A local Healthwatch within a system may also be able to assist in seeking the views of people across the system who have experienced hospital discharge.

Quality improvement

Understanding and applying the principles of measurement for improvement is vital to get the most out of data. Further information and resources can be accessed via the Improvement Fundamentals online courses and Quality, Service Improvement and Redesign programmes.

If parts of a pathway are proving a challenge to maintain or sustain, the specific stage can be looked at in more detail using quality improvement tools and methods. At each point in the Pathway, as this data becomes automated and part of a national data collection, benchmarking and understanding variation rather than target setting will enable an improvement rather than a performance approach. This will involve multiple small tests of change to bring the system back under control.

Case study

Data sharing across a local system

The Wirral local system share and analyse high-level data across the system on a weekly basis to detail performance, identify key issues or blockages, and review targets and associated measures. The mechanism for doing this is a weekly system meeting involving the three trusts (acute, community and mental health), CCG and local authority. The dataset discussed at the meeting includes:

- Discharge numbers across Pathways 0-3 in comparison to agreed system targets
- Facilitation of safe and expedient discharges across Pathways 0-3 – response times in comparison to agreed system targets
- Previous 7 days admissions versus discharges against planned trajectory
- Numbers of patients who do not meet the criteria to reside but have not been discharged in comparison to agreed system targets
- Progress against agreed metric for improving weekend discharges
- Community health, mental health, and social care capacity data

This system approach to sharing and analysing the data enables system-owned actions to be agreed. A weekly report is shared with the system Chief Operating Officers and risks and issues are escalated to them for action at the system leadership level if necessary.

Case study

Data sharing across a local system and use of time and date stamping

The Hull and East Riding Health and Care system have set up system-wide partnership agreements whereby patient flow huddles take place every morning, seven days a week to facilitate daily discharges, review capacity pressures and implement escalation protocols where necessary. Full data sharing between system partners has been agreed and implemented via a Tier 2 information sharing agreement signed-off at local system (place-based) level by the Information Governance leads of all organisations.

Patient-level data categorised by the responsible discharging provider and recommended discharge Pathways are shared by the acute trust and discussed with partner agencies. Internal operational escalation takes place twice a day (10.30am and 2.30pm), seven days a week. Time and date stamps and criteria to reside status are captured and specific actions with agreed owners are tracked in real-time, including not only acute therapy and ward-based actions but also community provider and local authority actions.

Community partners share on a daily basis the total community bed capacity and home care capacity available for use by the system. Data on ambulance handovers, system mental health capacity, COVID-19 infection rates and primary care OPEL levels are shared at daily system calls attended by designated senior managers from partner agencies.

Since the national hospital discharge guidance was introduced in 2020, Hull local authority has decommissioned 100% of their social care short-stay beds (circa. 15 beds). Most people are now discharged home via Pathways 0 or 1, with some going to a temporary community bed via Pathway 2, and a small number with more complex needs discharged on Pathway 3.

Commissioning

Commissioning

Different or additional commissioning practices may be required to support a Discharge to Assess model, where locally affordable and adopted. These may include:

- Collaborative commissioning between health and adult social care. This can also support and control the local market, achieving best value. Top tips for implementing a collaborative commissioning approach to Home First are available.
- Joint commissioning of care packages for those discharged with the local authority as 'lead commissioner' unless otherwise agreed between the Integrated Care Board (ICB) and local authority.
- Recruiting reablement assistants to join the team or commissioning existing agencies to fulfil that function.
- Working with new market sectors such as personalised care delivered via personal assistants and live-in care, and expanding care provision to include working-age adults.
- Creating a culture of collaboration with the independent care sector and voluntary and sector, including hospices.
- Promoting an understanding of a place-based approach that has strength-based plans as its base. This will include better and regular communications with the voluntary sector and user-led organisations, including those representing carers.

Local authorities and ICBs must agree a joint approach to improving discharge outcomes, which must include an account of how collaborative commissioning will support these, as part of their Better Care Fund plans.

For further guidance on commissioning for a Discharge to Assess model and Home First approach, please see Effective Commissioning for a Home First Approach.

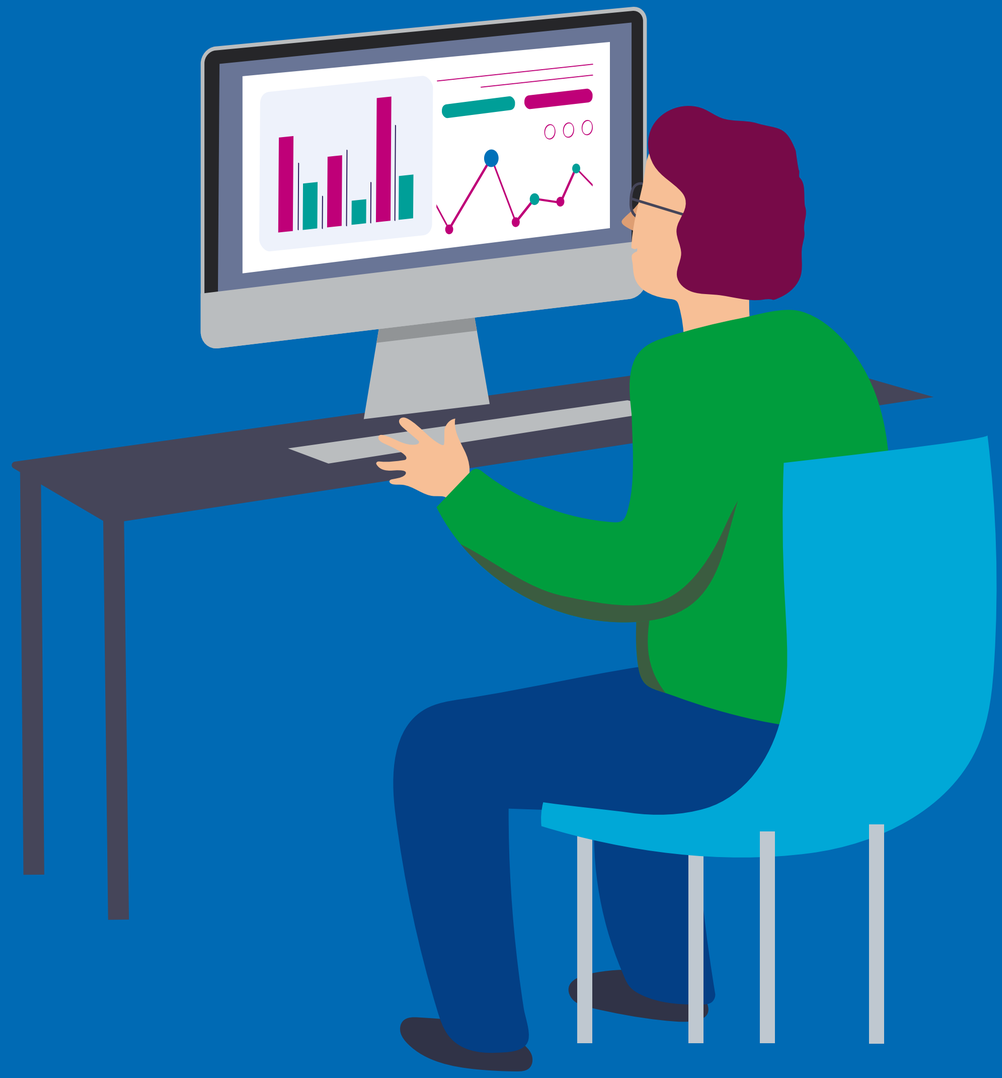
Case study

Collaborative commissioning

The Portsmouth and South East Hampshire local system have developed a collaborative commissioning approach to Home First and Discharge to Assess. They have a shared vision "to support people to live healthy, safe and independent lives by offering health and social care services that are joined up and provided in the right place, at the right time".

They have established three priority programmes around managing flow, place-based care and healthy communities to coordinate actions aiming to build resilience, join-up delivery, shift to out of hospital care and keep people at home. Achievements in relation to hospital discharge include additional domiciliary care (via shared winter grant planning), a daily care market SitRep, discharge and flow meetings, social workers working out of the acute trust, a telemedicine model in care homes and a shared SRO with delegated authority.

Training



Training

The Home First Act Now eLearning Programme is available now via e-Learning for Healthcare. The programme supports health and social care professionals involved in the discharge process to facilitate safe and timely discharge and ensure people are cared for in the best place for them. It covers the use of new technology to support discharge, effective early discharge planning and caring for people at home following discharge. Completing the online course can be used as evidence of continued professional development and ongoing learning.

Training resources are also available via Skills for Health, Skills for Care and the Future NHS Collaboration Platform via the Emergency Care and Improvement Support Team workspace: https://future.nhs.uk/ECISTnetwork/grouphome.

It is imperative that the workforce develops the knowledge, skills and confidence through training to embed and sustain a personalised care approach. In order to embed and sustain personalised care within integrated care systems, a triumvirate approach to training and bringing together prepared patients or Peer Leaders, a trained workforce and a supportive leadership system is required. The following accredited personalised care training is available to practitioners, people with lived experience and leaders to create system change:

- Peer Leadership Development Programme – developing Peer Leaders.
- Personalised Care Institute – developing clinician and practitioner personalised care knowledge and skills.
- Leadership for Personalised Care – developing system leaderships skills in personalised care.

Further resources

Further resources

Staff action cards

Effective implementation of Home First / Discharge to Assess will involve a wide range of health and social care professionals. Staff action cards have been produced to provide key information and outline the key responsibilities and actions for specific staff groups to help with implementation. They are available to download for the following staff groups:

- Medical Staff (Doctors)
- Matron, Ward Manager (Nurse in Charge)
- Acute Therapy Teams
- Bedded Rehabilitation (Therapies)
- Adult Social Care Teams
- Local System Commissioners
- Managers of the Discharge Team
- Members of the Discharge Team
- Single Coordinator
- Case Manager
- Transfer of Care Hub (Function)

Patient leaflets

Where there are ongoing health and/or social care needs after discharge with different care options available, people (and any carers, family or friends) should be empowered and supported to make the best choice for their individual circumstances. Patient leaflets have been produced to support staff to communicate and engage with people regarding their discharge from the point of admission to the point of discharge. They are available to download in 12 languages and Easy Read versions for use in the following circumstances:

- To be shared and explained to all persons on admission to hospital
  - Planning together: leaving hospital when the time is right
- To be shared and explained to all persons prior to discharge:
  - You are leaving hospital: returning home
  - You are leaving hospital: moving or returning to another place of care
  - Looking after family or friends after they leave hospital

Further resources, continued

Future NHS Collaboration Platform

Further resources can be found on the Future NHS Collaboration Platform via:

- Emergency Care Improvement Support Team workspace: https://future.nhs.uk/ECISTnetwork/grouphome
- Hospital Discharge and Recovery Programme and Reducing Long Length of Stay and Hospital Flow workspace: https://future.nhs.uk/RLHSNN/grouphome
- Better Care Exchange: https://future.nhs.uk/bettercareexchange
- Personalised Care Collaborative Network: https://future.nhs.uk/PCCN

FutureNHS

Further case studies

Further case studies have been published here.

https://www.england.nhs.uk/urgent-emergency-care/improving-hospital-discharge/case-studies/

Annex

Annex A: Criteria to Reside

Maintaining good decision making in acute settings

Academy of Medical Royal Colleges

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.

Contact us

If you have any queries, please get in touch with us using the details below:

NHS England and NHS Improvement National Hospital Discharge Programme Team: england.d2a@nhs.net

Local Government Association Care and Health Improvement Programme: chip@local.gov.uk