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Department of Health & Social Care

NHS England

Statutory guidance

Hospital discharge and community support guidance

Updated 26 January 2024

Applies to England

Contents

This publication is available at https://www.gov.uk/government/publications/hospital-discharge-and-community-support-guidance/hospital-discharge-and-community-support-guidance

Summary of changes - January 2024

This guidance has been updated. We have added detail on:

- the duty to co-operate - the guidance now outlines that NHS bodies and local authorities should agree the discharge models that best meet local needs and are effective and affordable within the budgets available to NHS commissioners and local authorities. This reflects the amendment to section 82 of the NHS Act 2006 made by the Health and Care Act 2022
- involving families and carers - the guidance now specifies that NHS bodies and local authorities should ensure that, where appropriate, unpaid carers and family members are involved in discharge decisions. This reflects the amendment to section 74(1) of the 2014 Care Act made by the Health and Care Act 2022
- care transfer hubs - the guidance contains more specific information on good practice in use of care transfer hubs to manage discharges for people with complex needs, including the example of Croydon's care transfer hub

We have also updated the guidance to clarify the discharge to assess process, with Annex A providing details on the operational process of discharge to assess.

Annex B sets out the 4 pathways under the discharge to assess model and clarifies the position for those who are ordinarily resident in a care home:

- pathway 0: discharges home or to a usual place of residence with no new or additional health and/or social care needs
- pathway 1: discharges home or to a usual place of residence with new or additional health and/or social care needs
- pathway 2: discharges to a community bed-based setting which has dedicated recovery support. New or additional health and/or social care and support is required in the short-term to help the person recover in a community bed-based setting before they are ready to either live independently at home or receive longer-term or ongoing care and support
- pathway 3: discharges to a new residential or nursing home setting, for people who are considered likely to need long-term residential or nursing home care. Should be used only in exceptional circumstances

About this guidance

This is statutory guidance intended for NHS bodies, including NHS England, English special health authorities, NHS trusts, NHS foundation trusts and integrated care boards (ICBs), as well as local authorities and integrated care partnerships (ICPs) in England. For the purposes of this guidance, the term 'NHS bodies' does not include Welsh NHS bodies. These organisations will henceforth be referred to as NHS bodies and local authorities.

For queries relating to this guidance, contact ascdischargepolicy@dhsc.gov.uk.

Section 82 of the National Health Service Act 2006

Section 82 of the National Health Service Act 2006 (https://www.legislation.gov.uk/ukpga/2006/41/contents) ('the NHS Act 2006') requires NHS bodies (on the one hand) and local authorities (on the other) to co-operate with one another in order to secure and advance the health and welfare of the people of England and Wales. Section 82 requires that NHS bodies and local authorities have regard to guidance issued by the Secretary of State for Health and Social Care on the discharge of the duty to co-operate.

This guidance, where it relates to the duty to co-operate, is issued by the Secretary of State for Health and Social Care under section 82 of the NHS Act 2006.

Section 74(2) of the Care Act 2014

Section 74 of the Care Act 2014 (https://www.legislation.gov.uk/ukpga/2014/23/contents/enacted) states that where a relevant trust is responsible for an adult hospital patient and considers that the patient is likely to require care and support following discharge from hospital, the relevant trust must, as soon as is feasible after it begins making any plans relating to the discharge, take any steps that it considers appropriate to involve the patient and the carer of the patient.

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. The term ‘unpaid carer’ will be used throughout this guidance to refer to such persons.

In performing this duty in accordance with section 74 of the Care Act 2014, a relevant trust must have regard to any guidance issued by NHS England.

This guidance, where it relates to the duty under section 74 of the Care Act 2014, is issued by NHS England. Unpaid carers are mentioned throughout the guidance, but much of this content is in section 12 of this guidance.

Where this guidance refers to the duty to co-operate, it sets out how NHS bodies and local authorities should co-operate to plan, commission and deliver hospital discharge and recovery services from NHS acute hospitals, NHS community hospitals and virtual wards that are effective and affordable within the budgets available to NHS commissioners and local authorities. Community settings may include settings for recovery services or community hospitals. This guidance applies to NHS bodies and local authorities exercising health and adult social care functions in England and should be used to inform local service planning and delivery.

This guidance applies in relation to adults being discharged from NHS acute hospitals, NHS community hospitals and virtual wards. It excludes maternity patients. Discharges from mental health hospitals is covered by separate guidance: Discharge from mental health inpatient settings (https://www.gov.uk/government/publications/discharge-from-mental-health-inpatient-settings).

This guidance sets out the practical expectations for co-operation between NHS bodies and local authorities under specific circumstances pertaining to hospital discharge. It aims to provide greater clarity about what the duty to co-operate means in practice, and to reinforce the importance not only of NHS bodies collaborating effectively, but also of NHS bodies working closely with local authorities and adult social care providers. This guidance builds on the innovation, collaborative working relationships and positive behaviours that are already happening and aims to help further embed these behaviours across the health and care system.

It is essential that this duty to co-operate is considered within the context of integrated care systems (ICSs) to ensure that discharge processes and services are integrated across local areas where possible, helping to facilitate the joined-up, person-centred care that is central to both people receiving care and the unpaid carers and family members who support them.

There is information throughout this guidance that may also be of benefit to care providers, housing services and providers and the third sector.

Introduction

Hospital discharge is the final stage in an individual's journey through hospital following the completion of their acute medical care, when they leave an acute setting and move to an environment best suited to meet any ongoing health and care needs they may have. This can range from going home with little or no additional care (simple discharge), to a short-term package of home-based or bed-based care and recovery support in the community, pending assessment of any longer-term care needs (complex discharge). Whether at home or in a community setting, individuals should be discharged to the best place for them to continue recovery (if needed) in a safe, appropriate and timely way.

Local areas should adopt discharge processes that best meet the needs of the local population. In this guidance, 'local areas' is used as a collective term for NHS bodies (including ICBs, NHS trusts and NHS foundation trusts) and local authorities exercising functions in England. NHS bodies and local authorities in local areas should work together to plan, commission and deliver discharge services that are effective and affordable within the budgets available to NHS commissioners and local authorities, pooling resources where appropriate.

Under the discharge to assess model and home first approach (https://www.local.gov.uk/our-support/our-improvement-offer/care-and-health-improvement/systems-resilience/overall-approach/discharge-to-assess) to hospital discharge, the vast majority of people are expected to go home (that is, to their usual place of residence) following discharge. The discharge to assess model is based on evidence that the most effective way to support people is to ensure they are discharged safely when they are clinically ready, with timely and appropriate recovery support if needed. It is best practice that any assessment of longer-term (ongoing) needs should be anticipated and initiated during a person's recovery journey but not fully completed until the person has reached a point of recovery and stability where it is possible to make an accurate assessment. The transition from recovery support to ongoing support should be seamless.

Other than in exceptional circumstances, no one should be discharged directly into a permanent care home placement for the first time without first giving them an opportunity to recover in a temporary placement before assessing their long-term needs.

When it becomes apparent that someone may need support from social care services to aid their discharge and recovery, NHS trusts should inform the relevant local authority of this need as early as possible in the person's hospital stay, to allow local areas to co-operate on the person's discharge

planning. This should be the case in every instance where it is considered someone may have ongoing social care needs.

Multidisciplinary discharge teams and care transfer hubs (see section 5 of this guidance), comprising professionals from all relevant services across sectors (such as health, social care, housing, the voluntary and community sector), should work together alongside the person being discharged and their carer or family, where relevant, to plan the person's discharge. NHS bodies and local authorities have a statutory duty to co-operate in exercising their respective functions, including as they relate to hospital discharge, under section 82 of the NHS Act 2006 (see section 6 of this guidance).

This approach reduces exposure to risks such as hospital-acquired infections, falls and loss of physical and cognitive function by reducing time in hospital, and enables people to regain or achieve maximum independence and quality of life as soon as possible[footnote 1]. It also supports hospital flow, maximising the availability of hospital beds for people requiring inpatient care and elective surgery.

Local areas should agree how to use their resources most effectively to improve discharge including, where necessary, developing more home-based, strengths-based care (drawing on the person's strengths and assets) and support, and reducing reliance on bed-based provision. Home may be someone's own home or usual place of residence.

Local areas should, as far as possible, offer choice for individuals on what care and support they receive on discharge from hospital. Individuals should be supported to make fully informed decisions, in conjunction with their wider family or unpaid carers (where appropriate, and where the individual consents), their independent advocate or, where a person lacks the capacity to consent, their lasting powers of attorney (LPA) responsible for health and welfare, if they've appointed one. This process should be person-centred, strengths based and driven by choice, dignity and respect. This may take the form of a multidisciplinary team discussion on the person's care plan and post-discharge needs, or alternative conversations where care planning is discussed.

> A lasting power of attorney (LPA) (https://www.gov.uk/power-of-attorney) is a legal document that allows someone to appoint one or more people to help them make decisions or to make decisions on their behalf. Throughout this guidance we use the term 'LPA' to refer to the legal arrangement itself, and also to the person who has been granted authority under lasting power of attorney.

If a person's preferred care package or placement is not available once they are clinically ready for discharge, an available alternative that is appropriate for their short-term recovery needs should be offered while they await

availability of their preferred choice. People do not have the right to remain in an acute or community hospital bed if not clinically indicated, including to wait for their preferred option to become available.

This guidance is based on the experiences of individuals, unpaid carers and practitioners and organisations with health and care experience, as well as input from leaders of NHS and local government services.

Structure of this guidance

The overarching aim of this guidance is to set out how the NHS and local authorities can work together to plan and implement hospital discharge, recovery, rehabilitation and reablement in the community

The guidance has been structured around 3 themes:

- the care journey
- roles and responsibilities
- specific needs

Within these themes, there are 14 numbered sections relating to the principles underpinning this guidance, as follows:

1. NHS bodies and local authorities should agree the discharge models that best meet local needs and are effective and affordable within the budgets available to NHS commissioners and local authorities

2. NHS bodies and local authorities should ensure that, where appropriate, unpaid carers and family members are involved in discharge decisions

3. Planning for discharge should start on admission, or before for elective procedures

4. People should be supported to be discharged to the right place, at the right time, and with the right support that maximises their independence and leads to the best possible sustainable outcomes

5. Local areas should develop a discharge infrastructure that supports safe and timely discharge to the right place and with the right treatment, care and support for individuals

6. Joint accountability across health and social care leads to better outcomes

7. Health and local authority social care partners should support people to be discharged in a timely and safe way as soon as they no longer

require care in NHS acute hospitals, NHS community hospitals and virtual wards

8. Assessing for long-term needs at an optimised point of recovery or stability improves people's outcomes

9. Discharge requires active risk management across the system

10. Palliative and end of life care needs should be anticipated and met as part of an individual's discharge journey

11. Information should be shared across relevant health and care teams and organisations across the system in a secure and timely way to support best outcomes

12. Planning and implementation of discharge should respect an individual's choices and provide them with the maximum choice and control possible from suitable and available options

13. Mental capacity, advocacy and special arrangements for discharge

14. NHS bodies and local authorities should ensure people receive support that is tailored to their specific needs and circumstances

The care journey

1. NHS bodies and local authorities should agree the discharge models that best meet local needs and are effective and affordable within the budgets available to NHS commissioners and local authorities

NHS bodies and local authorities should adopt discharge processes that, in their judgement, best meet the needs of the local population and, where possible, take account of choice and preferences. This includes the discharge to assess model and home first approach. Funding to support discharge can be pooled across health and social care through an agreement under section 75 of the NHS Act 2006 to minimise delays. This can facilitate effective use of available resources and ensure the decisions about an individual's care needs are made in their own environment. Local areas can choose the appropriate funding mechanisms to enable these

processes, such as the Better Care Fund (https://www.england.nhs.uk/ourwork/part-rel/transformation-fund/better-care-fund/) (BCF), or other means that are affordable within the budgets available to NHS commissioners and local authorities. For example, the BCF can, subject to local agreement, continue to be used to enable an integrated approach to services at the interface of health and social care, such as intermediate care and discharge planning, as well as core adult social care services and respite breaks for unpaid carers.

Discharge to assess

Introduced as best practice in 2016 by NHS England, the 'discharge to assess' (or D2A) model involves providing short-term care, rehabilitation and reablement, where needed, and then assessing people's longer-term needs for care and support once they've reached a point of optimal recovery. This may be in people's homes or using 'step-down' beds to support the transition from hospital to home. This means that people do not wait unnecessarily in hospital where there is a higher risk of acquiring infections or deconditioning. Assessing people out of hospital in the most appropriate setting and at the right time for them supports people's independence and long-term outcomes, reduces discharge delays and improves patient flow. You can read more about the discharge to assess process in Annex B, below, and in Professor Martin J Vernon's blog page (https://www.england.nhs.uk/blog/martin-vernon-3/) on the NHS England website.

This guidance seeks to support NHS bodies and local authorities to agree how to use their resources to deliver the best possible outcomes for their population. Post-discharge care, when delivered in the right setting and appropriate for the person's care needs, not only leads to better outcomes for the individual, but is also a better use of resources.

NHS bodies and local authorities should ensure that local funding arrangements are agreed co-operatively with one another and are aligned with existing duties, including those under the Care Act 2014, the Mental Capacity Act 2005 (https://www.legislation.gov.uk/ukpga/2005/9/contents) and the Mental Health Act 1983 (https://www.legislation.gov.uk/ukpga/1983/20/contents). This includes the requirement under The Care and Support (Preventing Needs for Care and Support) Regulations 2014 (https://www.legislation.gov.uk/uksi/2014/2673/contents/made) that, where intermediate care including reablement is provided by local authorities, it is provided free of charge for up to 6 weeks.

In 'cross border' situations where a person might be placed for short-term care in a community bed-based setting that is outside of their 'home' area, responsibility for funding that care should be determined in accordance with

the Who Pays? (https://www.england.nhs.uk/publication/who-pays-determining-which-nhs-commissioner-is-responsible-for-commissioning-healthcare-services-and-making-payments-to-providers/) rules for services that are for the NHS to fund, and with reference to 'ordinary residence' rules for services that are funded by local authorities. The different rules used for determining NHS and local authority responsibility may sometimes mean that someone who is the responsibility of one ICB is the responsibility of the neighbouring local authority (or the other way round). In 'cross-border' situations of this kind, especially where the issue arises on a regular basis, the ICB and local authority should agree local arrangements to ensure that any decisions about the joint funding of care can be made swiftly, so that there is no adverse effect on timely discharge.

Local areas should ensure clear information is also available for people who may need to self-fund ongoing care, so they can make informed choices about any ongoing care needs that do not fall within publicly funded eligibility criteria.

NHS bodies and local authorities should consider how capacity across local health and social care providers can best be used to support people in their own homes or usual place of residence.

Where local areas agree to fund a period of recovery care and support, agreements should be in place to ensure no one is left without this care and support or, if needed, an assessment of long-term needs at the end of this period. They should also ensure that no carers are left without adequate support or a carer's assessment (if needed) at the end of this period. Carer's support, if required, should form part of a person's care plan.

Regardless of the discharge, community support and funding model that is adopted locally, people and, where relevant, their families, unpaid carers, LPAs and independent advocates, should expect to receive personalised support that meets their needs and maximises the person's independence. People may be entitled to independent advocacy if they do not have a friend or family member to support them during the discharge process. More information is set out in section 13 of this guidance.

People should not be routinely discharged to a community step-down bed simply to free up a hospital bed, nor should they routinely be discharged to a community bed simply because home-based care is not available. Where this does happen, it should be a short-term solution and reviewed quickly following discharge. Effective demand and capacity planning will support the provision of adequate therapy and rehabilitation packages.

For guidance on patient choice in relation to hospital discharge and community recovery support, see section 12 of this guidance.

2. NHS bodies and local authorities should ensure that, where appropriate, unpaid carers and family members are involved in discharge decisions

Family members, friends and other unpaid carers play a vital role in the care of people who are discharged from acute and community settings. NHS bodies and local authorities should address local barriers to identifying and supporting unpaid carers throughout the discharge process. This includes ensuring local authorities continue to adhere to their duties in existing legislation, for example, those outlined in the Care Act 2014 and the Children Act 1989 (https://www.legislation.gov.uk/ukpga/1989/41/contents).

From the outset people should be asked who they wish to be involved and/or informed in discussions and decisions about their discharge, and appropriate consent received. This may include a person's family members (including their next of kin), friends or neighbours. The Health and Care Act 2022 (https://www.legislation.gov.uk/ukpga/2022/31/contents/enacted) amended section 74(2) of the Care Act 2014 to include a duty for NHS trusts and NHS foundation trusts. Under this duty, they must involve patients and unpaid carers (including young carers) as soon as it is feasible in discharge planning for adult patients who are likely to need care and support after their discharge, where they consider it appropriate to do so. Paid care workers and personal assistants should also be involved, to ensure that any changes that may be needed to someone's support plan can be reflected in a timely manner to best support their recovery or end of life care.

The relevant NHS trust should make a determination as early as possible in discharge planning - or as early as possible during a period of recovery - about the status and views of any unpaid carers who provide care, including that they are willing and able to provide support and care after discharge. This will need to be age appropriate if this is a young carer under the age of 18 and staff should identify any safeguarding issues for both the adult and the young carer.

NHS bodies and local authorities will need robust systems to identify unpaid carers, including young carers, early in the discharge process. This should involve identifying any children or young people in the household who have caring responsibilities, or who may have new responsibilities at the point of discharge. This may include children or young people taking on a greater caring role in relation to a disabled sibling or other child in the family, as well as providing care to a parent following discharge.

Where a young carer is identified, or any professionals responsible for care planning have concerns that the person will be discharged into the care of a person under the age of 18, the local authority should be notified of this

information. Upon notification, the local authority must carry out an assessment in accordance with their responsibilities under section 17 of the Children Act 1989 (https://www.legislation.gov.uk/ukpga/1989/41/section/17) where it appears to the authority that the young person may need support or on request from the young carer or their parent. Any assessment must be conducted in accordance with the Young Carers (Needs Assessments) Regulations 2015 (https://www.legislation.gov.uk/uksi/2015/527/made), taking into account the young carer's age, understanding and family circumstances.

Local authority assessments must also consider whether it is appropriate or excessive for the young carer to provide care for the person in question, in light of the young carer's needs and wishes. When involving young carers in discharge planning, it is important to consider whether there are any safeguarding issues for the young carer, as well as for the person they are caring for. NHS and local authority staff should know who to refer any concerns to and bear in mind the Working Together to Safeguard Children (https://www.gov.uk/government/publications/working-together-to-safeguard-children--2) guidance. The Act sets out that the NHS has a duty to co-operate with local authorities in exercising these responsibilities.

The relevant local authority should undertake a carer's assessment before caring responsibilities begin if this is a new caring duty, or, if there are increased care needs, a review of the previous carer assessment and support plan. If the assessment needs to take place prior to discharge, it should be organised in a timely manner so as not to delay discharge from hospital. Section 10 of the Care Act 2014 requires local authorities to carry out an assessment where it appears that an unpaid carer may have needs for support at that time, or in the future, and to draw up a support plan for how these needs will be met. Should unpaid carers have substantial difficulty engaging in their own assessment, they should be referred for independent advocacy support under the Care Act 2014. Young carers in particular may benefit from independent advocacy support.

Recording unpaid carers' details in electronic patient records can be one way to facilitate the identification and recognition of unpaid carers, particularly in cases where the individuals they are caring for experience repeat admissions. There is also the opportunity to identify the unpaid carer on their own patient record.

Not all individuals who are (or will be) providing ongoing care will identify as an 'unpaid carer'. If the person is nevertheless acting in the role of an unpaid carer, they should be regarded as one and involved in key conversations about the care needs of an individual after their discharge from hospital, or in having their own needs assessed. In other cases, the person being discharged may themselves have caring duties, such as being a parent of a child with a disability. 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.

Local areas should also take care to identify any LPAs that may be relevant and should consult them when appropriate.

Parents in this situation should be made aware of their right to an assessment of their needs (as set out in section 97 of the Children and Families Act 2014) and any additional services the local authority may need to put in place to support them in fulfilling their caring role for their child. This could include, for example, the provision of a short break or respite care to support the family.

There are instances where relationships are abusive: the individual or their unpaid carer may be abused, may abuse or be neglectful, or may have key information about abusive others. Safeguarding protocols should be followed where abuse, or risk of abuse, is identified, or staff members have concerns about abuse.

3. Planning for discharge should start on admission, or before for elective procedures

Planning for discharge should begin on admission. Where people are undergoing elective procedures, this planning should start pre-admission, with plans reviewed before discharge. This will enable the person and their family members or unpaid carers to ask questions, explore choices and receive timely information to make informed choices about the discharge pathway that best meets the person's needs. Further detail on the 4 discharge to assess pathways is set out in Annex B, below.

Where there is a personalised care and support plan or personal wellbeing plan already in place, this should be used or updated as part of early discharge planning involving the person receiving care and relevant parties such as unpaid carers, family members, their current care provider and voluntary and community sector services to ensure any change in their needs can be met. This should, where relevant, be complemented by the use of a Comprehensive Geriatric Assessment (https://www.nice.org.uk/guidance/QS136/chapter/Quality-statement-2-Comprehensive-geriatric-assessment) as a tool to support discharge planning for older adults with complex needs.

Multidisciplinary teams (see section 4 of this guidance) working across health and social care under the duty to co-operate should plan post-discharge care, long-term needs assessments and, where appropriate, end of life care. Social workers, including children's social workers of young carers and young adult carers, should be involved at an early stage of the discharge planning process where appropriate, including where that planning takes place in a hospital setting. The team should also ensure that

any mental capacity and safeguarding concerns have been considered alongside other support needs post-discharge. Multidisciplinary teams should make use of the Capacity Tracker (https://www.necsu.nhs.uk/capacity-tracker/) and other data sources to identify what local services are available. The searchable database of vacancies includes Care Quality Commission (CQC) registered care homes, community rehabilitation, substance misuse and hospice locations.

Discharge planning should include information about post-discharge care, such as advice and information about voluntary and community sector organisations, housing options (such as home adaptations, the Disabled Facilities Grant (https://www.gov.uk/disabled-facilities-grants) (DFG) and possible alternative housing) and NHS and/or social care crisis response teams that can be contacted if needed.

Unpaid carers, including family members, providing care for the individual, should be offered support when they are identified. For example, all unpaid carers may benefit from signposting to local carers' support services or voluntary services[footnote 2] or referred to their local authority for a Carer's Assessment.

The Care Act 2014 requires local authorities to deliver a wide range of sustainable high-quality care and support services, including support for unpaid carers, and local authorities are required to undertake a Carer's Assessment for any unpaid carer who appears to have a need for support and to meet their eligible needs on request from the carer. This is an opportunity to record the impact caring has on a carer and will look at all of the carer's needs, including whether they are willing or able to continue caring. If a carer is assessed as having needs that are eligible for support, then the local authority has a legal duty to meet these needs on request from the carer and to draw up a support plan with the carer setting out how these needs will be met.

4. People should be supported to be discharged to the right place, at the right time, and with the right support that maximises their independence and leads to the best possible sustainable outcomes

Health and care professionals who are facilitating discharges should work together with individuals, and - where relevant - families and unpaid carers to discharge people to the setting that best meets their needs, which for the majority of people will be their own home. This process should be person-centred, strengths-based and driven by choice, dignity and respect.

The vast majority of discharges should be simple discharges as the individuals involved can go home without the need to arrange additional onward care or support. Even so, it is important that non-clinical factors are considered, and any unpaid carer involved, to ensure safe and effective discharges. Of those with more complex needs, the majority can go home with short-term recovery support in place, with only a small proportion needing short-term bed-based care to aid their recovery.

Only in exceptional circumstances should someone be considered to need long-term care at the point of discharge and even then, under the discharge to assess model, other than in exceptional circumstances, they should be discharged to a temporary placement for assessment of their long-term or ongoing needs. See Annex B, below, for further details about pathways for the discharge to assess model.

Support should extend beyond discharge itself. Local areas should have agreed protocols for collaborating with onward care providers about the individual's hospital discharge through the care transfer hub (see section 11 on information sharing). This should include agreed pathways for raising any concerns post-discharge and how to resolve these where care providers may need changes made to care plans.

Community health and care services, including GPs and social care providers, should communicate with the individual and, where relevant, their unpaid carers. The services should track and manage the individual's recovery, and ensure that any change in the support needs of the individual (or their carer) is managed appropriately to maximise recovery.

People should be discharged to a familiar setting where possible, as they often respond well to the familiarity of their home environment when it is appropriate to support their needs. If required, people should receive recovery support in the community, such as home or bed-based intermediate care (including short-term rehabilitation, reablement and recovery) to enable them to regain their independence as far as possible. This can lead to a more accurate assessment of their future needs once they have reached an improved point of recovery. More information is set out in section 8 of this guidance.

Practitioners within acute and community health and local authorities should consider a range of factors when supporting the individual and their family, unpaid carers, LPA or independent advocate to decide an individual's care pathway and post-discharge care and support. This includes the individual's preferences, existing provision of care and whether unpaid carers are willing and able to support an individual's recovery. Practitioners should be aware of young carers or young adult carers involved in unpaid care and support, working with them respectfully and appropriately and ensuring they have necessary support in place.

Discharging people to the most appropriate place to meet their needs requires active risk management across organisations to reach a reasonable balance between safety at all times and independence. Where a person has mental capacity to make a decision about what care and support they would like on discharge, they should be supported to manage any risks by health and social care services.

Even where a professional (including medical professionals and social care professionals) disagrees with a person's choice, in most cases a person who has mental capacity to decide what care and support they would like on discharge, will make the final decision. If an individual with the relevant capacity refuses the provision of care, then ultimately this decision should be respected. More detail is set out in section 8 of this guidance.

It is best practice for a person's immediate recovery needs to be determined prior to discharge and a plan put in place on how to meet them. Anyone requiring formal care and support to help them recover following discharge should receive an initial holistic safety and welfare check on the day of discharge to ensure safety and care needs are met, co-ordinated through the care transfer hub (see section 5 of this guidance, and below for a case study on how a local area has established a care transfer hub). Following best practice, fuller assessments should take place as the person settles in their environment. People should not have to make decisions about long-term care while they are in crisis or in an acute hospital bed.

Local areas should draw upon a range of short and medium-term intermediate care services, depending on the severity of an individual's needs. For example, some people may benefit from voluntary sector support, or very short-term 'hospital to home' services to get them settled back home. Short-term (72-hour) reablement or live-in care services may also be useful to ensure individuals have care available while they settle at home, rather than being discharged to a community or care home bed.

People with ongoing mental health needs, a drug or alcohol dependence, a learning disability, dementia, those in the last few months of life, and a range of other factors and conditions may require specialised support in the community. This may include an allocated social worker or social care professional and/or support from community mental health or drug and alcohol services, to ensure their needs continue to be met. Anyone facing the loss of a loved one should be informed about how they can access specialist bereavement support. The needs of people experiencing homelessness will also need to be considered (see section 14 of this guidance). Local commissioning plans should include the provision of specialised support that meets the local population's needs.

Case Study: Croydon's care transfer hub
Croydon has a well-established history of joint governance and partnership working across local authorities, acute trusts, primary care,

the independent sector and voluntary and community organisations. Its care transfer hub was established to provide a central co-ordination function for complex discharges to improve outcomes for individuals and reduce the need for long-term care. Design and implementation of Croydon's local care transfer hub model is underpinned by 3 supporting pillars:

1. Ownership, responsibility and operational delivery
2. Funding
3. Joint commissioning

The care transfer hub undertakes demand and capacity planning and matching to optimise the use of resources and the 'Croydon pound' (for example, by preventing over-prescription of care), and to ensure the timely placement of patients onto appropriate discharge pathways.

Operating as part of the care transfer hub, the Integrated Intermediate Care team provides a single point of access for referrals across pathways 1, 2 and 3. They work in a multidisciplinary way to ensure wraparound support is delivered in the first 72 hours for patients returning home before an assessment of long-term needs can take place. Any necessary reablement and rehabilitation care is delivered free of charge for up to 6 weeks by dedicated locality teams in the North, South and Central areas, which have close links to GPs and primary care services.

Examples of innovative practice in Croydon include the development of the 'blended assessor' role which combines 2 formerly distinct roles - social worker and health band 6 discharge co-ordinator - into a single position with joint assessment responsibilities. This has simplified the process for assessing patients, without sacrificing either social care or clinical expertise, and helped ensure patients receive the right post-discharge and ongoing care.

Key to the success of the care transfer hub has been clearly defining the functions provided by the Integrated Intermediate Care team (such as case management, assessment, clinical input), assigning responsibility for these functions to specific professionals, teams or sectors, and embedding this knowledge across system partners to ensure a shared understanding of roles and accountabilities.

Structure, roles and responsibilities

5. Local areas should develop a discharge infrastructure that supports safe and timely discharge to the right place and with the right treatment, care and support for individuals

Local areas should develop and implement the discharge model that best meets the needs of their local population and is affordable within the budgets available to NHS commissioners and local authorities. Discharging an individual onto the right care pathway when they no longer need to remain in acute or community care requires a whole system approach. NHS bodies have a duty to co-operate with local authorities, and they should work closely with adult and children's social workers, care providers, housing support, voluntary and community sectors and others to ensure people's care and treatment is timely, optimal and co-ordinated, while also minimising delays when they are ready to be discharged.

Senior level support from NHS providers and local authorities should provide strategic leadership and oversight of the discharge process to monitor and eliminate the causes of unnecessary discharge delays and ensure that the agreed discharge procedures are being followed consistently. Data, including on patient, carer and staff experience, should be used to inform, measure and drive quality improvement.

NHS bodies, local authorities and other relevant partners should develop joint working arrangements for discharge co-ordination. These should set out each organisation's role and how responsibilities should be exercised, to ensure appropriate discussions and planning concerning a person's short and long-term care options happen at the appropriate time in their recovery.

To ensure discharge processes are effective, NHS bodies and local authorities should ensure recovery support, including intermediate care (short-term rehabilitation, reablement and recovery services) is commissioned effectively and sustainably. Services should meet the needs of the local population and be affordable within the budgets available to NHS commissioners and local authorities. This should be done in collaboration with relevant organisations, including the voluntary and community sector and care providers.

The support needs of specific populations should be considered when commissioning local services (see section 14 of this guidance). This includes determining the type of specialist rehabilitation services needed for people with complex conditions and ensuring appropriate social work provision and other specialist support is in place for people in complex, abusive or neglectful relationships. The involvement of advocacy should also be a key consideration where appropriate.

Local areas should also determine the best working arrangements of multidisciplinary health and care teams who manage discharge from acute and community hospitals and virtual wards, whether they choose to co-locate their staff, work together using virtual systems, or find other means of effective collaboration through the care transfer hubs. The workforce needs to work flexibly to inform integrated care pathways across primary and secondary care to help co-ordinate care and meet increasing health complexity and population need.

Commissioners should work with local voluntary and community sector organisations to develop and maintain capacity in the community to support people, including those who do not need specific reablement or rehabilitation, to retain links into the community and maintain their wellbeing.

Specific roles, structures and responsibilities

Every local health and social care system should give regard to best practice in relation to discharge processes. Some of the features of best practice models are listed below. Detailed guidance on accountability and roles can be found in Hospital discharge and community support: staff action cards (https://www.gov.uk/government/publications/hospital-discharge-service-action-cards).

Identified executive lead
An identified executive lead, employed by any partner in the system, to provide strategic oversight of the discharge process. They should ensure that appropriate procedures are followed, including the inclusion and support of carers, to minimise avoidable delays to discharge.

Single co-ordinator
A single co-ordinator who acts on behalf of the system to ensure safe and timely discharge on the appropriate pathway for all individuals. This system leadership role can be employed by any partner in the system. Their primary function is to develop a shared system view of discharge, hold all parts of the system to account and drive the actions that should be taken as a system to address shared challenges. The single co-ordinator is accountable to the executive lead.

Care transfer hubs
Care transfer hubs (or other co-ordination hub or single point of access) are made up (physically and/or virtually) of multidisciplinary teams (such as health, social care, housing and the voluntary and community sector). They work in an integrated way providing autonomous clinical, professional decision-making to support the planning of complex discharges, and to broker the required support through adult social care, intermediate and community health services. The development of these hubs is supported by best practice guidance published in May 2022

(Hospital discharge and community support: staff action cards), and will be delivered in every hospital as part of NHS England's Delivery plan for recovering urgent and emergency care services - January 2023 (https://www.england.nhs.uk/long-read/delivery-plan-for-recovering-urgent-and-emergency-care-services-january-2023/).

Case management approach

A case management approach should be applied to all individuals being discharged through the care transfer hub to support their discharge and recovery. Each individual should be clearly assigned to a member of care transfer hub staff at any one point, even if that staff member changes over time, for example because of working patterns. A case manager would be expected to work with the care transfer hub to arrange for an individual to have an initial holistic safety and welfare check on the day of discharge to ensure safety and care needs are met and allow time for fuller assessments to take place as the person settles. A case manager would also monitor and support progress against agreed goals in the individual's support plan, ensuring adjustments are made or the support stopped if necessary.

Hospital discharge multidisciplinary teams

Hospital discharge multidisciplinary teams describe - with input from the person and their unpaid carer, family members, advocate, or relevant community-based professionals - the needs that require support after discharge before an assessment of their long-term needs. This could include non-clinical factors like their physical, social, psychological, cognitive, financial and practical needs, including home adaptations and equipment. This could determine whether the person's home is suitable for their needs upon discharge. Multidisciplinary teams may include social workers, clinicians, therapists, mental health practitioners, pharmacists, care workers, dietitians, housing representatives, voluntary and community sector services and any other specialists needed to co-ordinate care for the individual. They should adopt strengths-based and person-centred planning, working together to plan care and carry out joint assessments.

These teams should be aware of both the duty to involve unpaid carers in discharge planning, where appropriate, and the duty for a local authority to assess an unpaid carer's need and discuss whether they are willing and able to care, and what support they would need to care safely when it is appropriate to do this. This helps to facilitate an integrated transition from hospital to the person's usual place of residence. Safety should be ensured from the day of discharge. They should refer those requiring support to the care transfer hub. If a person requires short-term care in a residential setting, hospital discharge multidisciplinary teams should use the Capacity Tracker to identify suitable vacancies.

Hospital-based social workers

Hospital-based social workers have a vital role as members of a discharge multidisciplinary team, ensuring a person-centred and strengths-based approach is adopted during pre-admission, hospital stays and planned safe discharge. Their role in hospital and assessment settings is essential for people whose social circumstances are complex. These social workers are experienced in supporting people to make informed choices, weighing up the risks and benefits of options, and they are familiar with mental health, mental capacity and safeguarding issues. They will also be knowledgeable about carers' rights. They will understand the full options available to people in community settings in order to offer people the best choice and understanding of their recovery pathway. They should use the Capacity Tracker to identify suitable vacancies if a person whose discharge they are supporting requires a residential bed to recover in.

Discharge planning
It is critical that general practice and other primary care providers, as well as social care and community providers, are directly linked into all discharge planning to ensure that health recovery support is available to the individual throughout their care journey. Social care providers must keep the required Capacity Tracker data updated in line with the Adult social care provider information provisions: data collection (https://www.gov.uk/government/publications/adult-social-care-provider-information-provisions-data-collection) statutory guidance.

6. Joint accountability across health and social care leads to better outcomes

Health and social care practitioners, working in a co-ordinated and integrated way, have the ability to support safe and effective hospital discharge. Integral to this is:

- person-centred care
- multidisciplinary teams facilitating discharge planning, for example through a care transfer hub, which takes place from admission
- collaborative and partnership working
- flow of information across organisational and professional boundaries

In its 2018 report, Beyond barriers: how older people move between health and care in England (https://www.cqc.org.uk/publications/themed-work/beyond-barriers-how-older-people-move-between-health-care-england), CQC highlighted that it is important that discharges are timely, safe and tailored to people's

needs. This includes ensuring joined-up planning and sharing of information with services in the community to ensure the right onward care and support is available and in place for the individual.

Co-operation duties

Section 82 of the NHS Act 2006 (https://www.legislation.gov.uk/ukpga/2006/41/section/82) requires NHS bodies and local authorities to co-operate with one another to secure and advance the health and welfare of their local population. NHS bodies and local authorities must also comply with duties in the Care Act 2014, which requires them to co-operate with each other in the exercise of their respective care and support functions, including those relating to carers and young carers (more detail is set out below).

Best practice

To implement best practice, NHS bodies and local authorities should work together to:

- ensure discharge planning starts at the point of admission, or before for elective surgeries
- gather information on a person's current support, living situation and abilities as early as possible, and with consent share it appropriately with all professionals involved
- determine what support, if any, an individual needs after discharge, so that they are discharged on the pathway that best meets their needs
- appropriately refer qualifying individuals to independent advocacy services on admission, so their voice is heard during the discharge planning process
- plan, commission and deliver appropriate care and support that meets population needs and is affordable within the budgets available to NHS commissioners and local authorities
- understand the quality, cost and effectiveness of local treatment, care and support to inform people of their options
- use data that is available to identify suitable vacancies and availability for people who need support on discharge, such as the Capacity Tracker
- understand the role each organisation has in safeguarding and put appropriate safeguarding policies and procedures in place[footnote 3]
- take joint responsibility for the individual's and unpaid carer's (including young carers), welfare when making decisions about discharge and post-discharge support
- transfer people seamlessly and safely from hospital to their own home or a new care setting with joined-up care, based on clear, evidence-based and accurate assessments that fully represent the medical and psychological needs and social preferences of the person

- transfer information between settings clearly and in a timely way, including communicating any changes in support needs, medication and ability with relevant involved parties, such as unpaid carers, GPs and social care providers
- identify any unpaid carers, including young carers under the age of 18, and determine whether any carer is willing and able to provide care and, if so, what support they might need (including through use of young carers' needs assessments)

Planning, delivering and monitoring of discharge services

Local areas should agree governance structures that support clear planning, delivery and monitoring of quality and performance, and with clear routes to escalate issues where required. Local organisations should work together to:

- agree expected levels of quality, supported by quality surveillance mechanisms that encompass patient, carer and staff feedback and experience to monitor and improve outcomes
- agree expected levels of performance and performance management mechanisms to monitor and improve outcomes
- use agreed, reliable and shared data to inform daily decision-making, address issues and improve outcomes for people being discharged
- agree an executive lead and a single co-ordinator for the local health and social care system to lead and manage discharge across the system
- establish and implement a shared vision and ambition to maximise the number of people discharged home
- plan, deliver and monitor the effectiveness of local discharge and recovery arrangements
- seek feedback proactively from providers of care post discharge on how the discharge went in practice, and identify areas for improvement
- identify joint commissioning responsibilities and leadership
- establish how shared risk and resources will be managed to deliver improved outcomes for people being discharged in a way that is effective and affordable within the budgets available to NHS commissioners and local authorities

Legal duties on health and social care bodies

The Care Act 2014 sets out a single route to establishing an entitlement to care and support for adults with eligible needs for care and support, and the entitlement to support for carers. The act is also clear about the steps that local authorities must follow to work out this entitlement, and to help people understand the process. This includes a duty to assess and meet people's eligible care needs in relevant circumstances and to conduct a financial assessment where necessary.

Sections 2 and 3 of the 2014 Act require local authorities to take steps to prevent, reduce or delay needs for care and support for local people and with a view to ensuring integration of care and support services with health provision, including the provision of housing. Section 2 requires local authorities to have regard to identifying carers with needs for support that are not being met.

The Health and Care Act 2022 revoked schedule 3 to the Care Act 2014, which required long-term health and care needs assessments to take place before discharge from hospital. The Health and Care Act 2022 also provides the Secretary of State for Health and Social Care with the power to issue guidance on the duty to co-operate (between NHS bodies and local authorities) and amends section 74 of the Care Act 2014 to introduce a new duty to involve patients and unpaid carers early in discharge planning, where it is appropriate to do so. See section 12 of this guidance for more information.

NHS England and ICBs must comply with their duties in relation to NHS continuing healthcare and NHS-funded nursing care, as set out in the National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012 (https://www.legislation.gov.uk/uksi/2012/2996/contents/made), while having regard to the national framework for NHS continuing healthcare and NHS-funded nursing care (https://www.gov.uk/government/publications/national-framework-for-nhs-continuing-healthcare-and-nhs-funded-nursing-care).

CQC monitors, inspects and regulates services to make sure they meet fundamental standards of quality and safety. The fundamental standards set in law a clear baseline below which care must not fall, and CQC will be able to take enforcement action against providers that do not meet these standards. Health and social care providers must meet the requirements set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (https://www.legislation.gov.uk/uksi/2014/2936/contents/made), in which:

- regulation 9 provides that the care and treatment of people using services must be appropriate, meet their needs and reflect their preferences
- regulation 12 (2) (i) places a duty on providers when care is shared or transferred between them to work together and with the service user and other appropriate persons, to ensure that timely care planning takes place to ensure the health, safety and welfare of the service user. To comply with this regulation, care providers must, among other things, assess the risk to people's health and safety of receiving any care or treatment

CQC guidance for providers on meeting the 2014 regulations (https://www.cqc.org.uk/guidance-providers/regulations-enforcement/regulation-9-person-centred-care) states that providers must carry out, collaboratively with the relevant person, an assessment of the needs and preferences of the

person needing care and support. Assessments should be reviewed regularly and whenever needed throughout the person's care and treatment. This includes when they transfer between services, use respite care or are re-admitted or discharged. Reviews should make sure that people's goals or plans are being met and are still relevant (for further guidance, see the Health and Care Act 2022: adult social care information provisions (https://www.gov.uk/government/publications/health-and-care-act-2022-adult-social-care-provider-information-provisions/adult-social-care-provider-information-provisions-guidance-for-providers-on-data-collection) collection).

The Health and Care Act 2022 inserted new section 46B to the Health and Social Care Act 2008 which sets out new powers for CQC to review ICSs. Its assessments will provide the public and the system with independent assurance of how their ICS is performing, and in particular the effectiveness of joined-up working and integration. In this context, ICS is defined as the ICB, its partner local authorities and registered service providers in the ICB area.

NHS bodies and local authorities should ensure all legal responsibilities are met in relation to mental capacity and best interest decision-making, and in relation to people's entitlement to aftercare services following discharge from certain forms of detention under section 117 of the Mental Health Act 1983 (https://www.legislation.gov.uk/ukpga/1983/20/section/117).

NHS bodies also have a duty to refer a person who is homeless, or may be threatened with homelessness, to local authority homelessness or housing options teams under the requirements of the Homelessness Reduction Act 2017 (https://www.legislation.gov.uk/ukpga/2017/13/contents/enacted). More detail is set out in section 14 of this guidance.

Specific responsibilities of NHS bodies and local authorities in relation to hospital discharge are set out in detail in Annex C, below.

Escalation

Local health and social care systems should have escalation mechanisms for people with concerns about care and support that are clearly communicated to people using services, their families, their unpaid carers and advocates, and service providers. These should clearly set out who is responsible for what and at which step of the process they should be engaged.

Concerns should be escalated using the locally agreed escalation mechanism, overseen by the single co-ordinator reporting to the executive lead. Local areas will have flexibility over how this is implemented locally, but they should ensure mechanisms are agreed with all partners, and that there is a clearly identified responsible person at each stage of the discharge process. Escalation mechanisms should be co-designed with people, including unpaid carers, who have experience of escalating issues

in the past to ensure they work. How to escalate concerns should be included in discharge information.

Where a complaint needs to be raised against an NHS body, it should be made to them directly in the first instance. This can be done through the relevant body's complaints department, or its Patient Advice and Liaison Service (PALS) (https://www.nhs.uk/nhs-services/hospitals/what-is-pals-patient-advice-and-liaison-service/). PALS can also provide information about the NHS complaints procedure, including how to get independent help if needed. Where a complaint needs to be made by an individual or provider this should be raised directly with the NHS body providing the service in the first instance. A complaint can also be raised with the commissioner of the service. Where this does not yield satisfactory results, the complaint can be raised through the Parliamentary and Health Service Ombudsman (https://www.ombudsman.org.uk/).

Where a complaint needs to be raised against a local authority or care provider, it should be made to them in the first instance. If this does not yield satisfactory results, or the complaint is not answered within a reasonable time, a complaint can be raised through the Local Government and Social Care Ombudsman (https://www.lgo.org.uk/).

Individuals can also provide information to local Healthwatch organisations and CQC. Either of these may carry out a range of actions including inspecting the relevant body if it has the powers to do so.

7. Health and local authority social care partners should support people to be discharged in a timely and safe way as soon as they no longer require care in NHS acute hospitals, NHS community hospitals and virtual wards

Health and social care professionals should support and involve the patient to be discharged in a safe and timely way to ensure they do not spend longer than necessary in an acute or community hospital, or local authority run community setting. People should be discharged once they no longer need care in that setting. Timely discharge from acute settings improves a person's outcomes and reduces the risk of medical complications such as deep-vein thrombosis, hospital acquired infections and loss of independence[footnote 4]. Evidence suggests that even 10 days of bedrest is associated with significant muscle loss in older adults[footnote 5].

No person should be discharged until it is safe to do so. This should include ensuring that, where relevant and appropriate, any unpaid carers have been

consulted on whether they are willing and able to provide care and support after discharge. Young carers should be offered independent advocacy support if they want it, to support them to consider how they will be impacted.

The case study below outlines how discharge to assess has worked in practice in a local area.

Case study: North Yorkshire
In the Humber and North Yorkshire region, decisions on continuing healthcare were previously undertaken in the acute trust, leading to unnecessary delays for some patients in leaving hospital. Local authorities and NHS trusts implemented a discharge to assess model based around structured discharge pathways 1, 2 and 3 (more information on the pathways model can be found in Annex B). The implementation happened in stages.

Stage 1
The initial focus was on pathway 2, with people discharged, where appropriate, to a community bed or temporary residential care for up to 6 weeks through a trusted assessment agreement (see section 9 of this guidance for more information on trusted assessment schemes). During these 6 weeks the Integrated Locality Team manage the discharge home.

Stage 2
Next, for pathway 3, the objective was to not complete any decisions on continuing healthcare in an acute setting. Instead, beds in community settings were spot purchased so individuals could be cared for in a more appropriate environment while awaiting their continuing healthcare assessment.

Stage 3
Finally, for pathway 1, accredited trusted assessors were used to complete referrals to social care to enable people to return home with third sector support prior to assessment of their ongoing care needs. Under this pathway, people are discharged through Age UK's 'Home from Hospital' service with support provided for up to 6 weeks at home if required. The ward multidisciplinary team completes a single trusted assessment for ongoing care needs in the person's home, and this is then shared between social care and community health teams.

Impact
Since the introduction of discharge to assess, numerous benefits have been realised including a reduction in unnecessary continuing healthcare assessments and referrals, a reduction in discharge delays and elimination of continuing healthcare decisions being made in acute settings.

Key factors in successful implementation of the model included clear clinical leadership, taking a pragmatic approach, building positive working relationships and ongoing engagement across all system partners.

8. Assessing for long-term needs at an optimised point of recovery or stability improves people's outcomes

The 2018 National Audit of Intermediate Care (PDF, 1.16MB) (https://s3.eu-west-2.amazonaws.com/nhsbn-static/NAIC%20(Providers)/2018/2.%20NAIC%202018findings%20FINAL.pdf) indicates that intermediate care recovery services, typically delivered over a 6-week period, can increase levels of people's independence and can reduce the number of preventable readmissions to hospital. The audit found that 71% of individuals reported an improved dependency score after a period of home-based care, 85% reported an improvement after a period of bed-based care, and 66% for reablement care. As a result of rising levels of independence, we would expect fewer emergency readmissions and long-term social care needs, including a reduction on cost pressures.

Hospital readmissions are estimated to lead to additional costs of £1.6 billion annually (see CHKS's report, Hospital readmissions and the 30 day threshold (PDF, 105KB (https://www.chks.co.uk/userfiles/files/CHKS%20Report%20Hospital%20readmissions.pdf)). While this figure indicates the total cost of hospital readmissions for all reasons, if the necessary recovery services are in place discharge to assess can help lower some of these costs by reducing length of stay and the likelihood of unnecessary readmissions - for more detail, see Hospital discharge and preventing unnecessary admissions (https://www.scie.org.uk/care-providers/coronavirus-covid-19/commissioning/hospital-discharge-admissions) published by the Social Care Institute for Excellence.

Intermediate care may be provided to someone in their own home or a community bed-based setting to support their recovery following discharge. Intermediate care can include rehabilitation, reablement and recovery support from NHS or social care services and should be tailored to the individual's needs. These services should be delivered by multidisciplinary teams and can be provided to people at home, or as part of step-down bed-based care where appropriate.

High-quality intermediate care services can support a shorter length of hospital stay, decrease long-term care costs and increase the functional

outcomes of people receiving these services. Local planning for intermediate care services can support person-centred care by ensuring acute, community and social care is delivered in a seamless way by multidisciplinary, multi-agency teams working in integrated ways. This can reduce the administrative burden on systems, improve efficiency and productivity and improve individuals' experience of care.

It is best practice to determine a person's immediate recovery needs and put in place a plan on how to meet them prior to discharge. It is best practice to initiate assessments of longer-term health and/or social care needs during the period of recovery and complete them only once a point of recovery and stability is reached.

In the case of palliative and end of life care, assessments should take place when the person is as stable as they are likely to become. The assessments should take place at a point of recovery or stability when their long-term care needs are clearer. People with palliative and end of life needs, particularly those who may die within days or weeks, will have additional considerations, which are set out in section 10 of this guidance.

Local authorities have duties to assess and meet people's eligible care needs in relevant circumstances, and these assessments should be conducted in a timely manner, in accordance with their Care Act 2014 duties. It is best practice to undertake these assessments in a person's home to determine long-term care needs, more information on which can be found in the Care and support statutory guidance (https://www.gov.uk/government/publications/care-act-statutory-guidance).

If care, treatment or support is needed, the individual should be fully involved in considering what form that might take and in weighing up the risks and benefits of the options that are available. This includes, if required by the person, consultation with family members and any unpaid carers who are willing and able to provide care and support. A health and welfare LPA can only be used when the donor has lost the mental capacity to make the relevant decision for themselves. If the individual does not have any friends or family members to consult about these options, then an independent advocate could be consulted if the patient chooses this. An independent advocate should be offered in these situations. If there is a health and welfare LPA in place for someone who does not have the capacity to consent, then this person should be consulted.

Social care expertise is a central part of the process to determine people's long-term care needs following a period of recovery. It can maximise their independence, meet their needs and wishes and ensure they are fully aware of their options and the implications of each choice.

For those with the highest levels of complex, intense or unpredictable needs, screening and assessment of eligibility for NHS continuing healthcare should be at the right time and location for the individual and

when the individual's ongoing needs are clearer to enable an appropriate health and social care package to be provided. The full assessment of eligibility should normally take place when the individual is in a community setting. There may be rare circumstances where assessments for NHS continuing healthcare may take place in an acute hospital environment. The core underlying principle is that individuals should be supported to access and follow the process that is most suitable for their current and ongoing needs. Further information on how hospital discharge interacts with NHS continuing healthcare can be found in the national framework for NHS continuing healthcare and NHS-funded nursing care.

9. Discharge requires active risk management across the system

Under the duty to co-operate, multidisciplinary teams should work together, including through care transfer hubs, to co-ordinate complex discharges. They should manage risk carefully with the individual and their unpaid carer, representative or advocate, as there can be negative consequences from decisions that are either too risk averse, or do not sufficiently identify the level of risk. At one end of the scale, people may be discharged onto pathways which result in care in excess of their needs, and at the other end, individuals may not receive the care and support they need to recover.

Any onward care providers should be included early in the person's discharge planning. This allows more time for local capacity to be managed and suitable support to be put in place. People's care needs may also change, and there should be processes in place to ensure these needs are continuously reviewed and that the person is receiving appropriate support (see section 4 of this guidance).

Where a person has mental capacity to make a decision about their care and support at the point of discharge, health and social care professionals should support them to manage their own risk. Principle 3 of the Mental Capacity Act 2005 provides that a person cannot be treated as lacking capacity merely on the basis that they have made an unwise decision. More information can be found in section 13 of this guidance.

A study of 10,400 individuals' care pathways, People first, manage what matters (https://reducingdtoc.com/), found that of the people who experienced a delayed discharge, 32% to 54% were discharged to a setting where the levels of care were not suitable for their needs. Of these, 92 % were receiving more intense care than they needed, suggesting a barrier to them maximising their independence.

Individuals and local factors will determine how best to manage risk. For example, in areas covering a broad geography, a virtual care transfer hub may be one model that can facilitate multidisciplinary working to ensure information about individuals and any family or friends caring for them is shared effectively across organisations with their consent. Other areas may choose to co-locate key staff members from relevant organisations at a physical care transfer hub, such as in a local acute hospital. Alongside ensuring integrated working across health, housing, social care and other key organisations, assigning a single point of contact ensures that the individual or the family can communicate with professionals in a timely manner.

Supporting multidisciplinary working is also key to developing a shared approach to risk to support discharge. Huddles, trusted assessment, shadowing and peer learning can all support this.

Health and social care professionals working in NHS bodies and local authorities should ensure that ‘safety netting’ is provided whereby the individual is provided with advice on discharge. The person should be given the contact details of someone who they can talk to about their discharge and advised to make contact if they are concerned about anything.

People should not be asked to see their GP or go to the emergency department following discharge for issues with their social care, and they should only be followed up by a new team when the person’s relevant information has been handed over to the new team. Where appropriate, information provided to the person on discharge should be shared with anyone providing care for the person.

Trusted assessment
‘Trusted assessor’ schemes are a national initiative designed to promote safe and timely hospital discharges and reduce delays. It is based on providers adopting holistic needs assessments carried out by suitably qualified ‘trusted assessors’ working under a formal, written agreement. Trusted assessors must have the qualifications, skills, knowledge and experience needed to carry out health and social care assessments, and to formulate plans of care on behalf of adult social care providers.

For more information on designing and implementing trusted assessment schemes, see:

- CQC guidance on trusted assessors (PDF, 185KB) (https://www.cqc.org.uk/sites/default/files/20180625_900805_Guidance_on_Trusted_Assessors_agreements_v2.pdf)

- Local Government Association (LGA) guidance on trusted assessors (https://www.local.gov.uk/our-support/our-improvement-offer/care-and-health-improvement/systems-resilience/overall-approach/trusted-assessors)

Specific needs

10. Palliative and end of life care needs should be anticipated and met as part of an individual's discharge journey

Individuals requiring palliative and end of life care and support should have their palliative and end of life needs anticipated and planned as part of the discharge process. To address this, each individual should be offered a personalised care and support plan (https://www.england.nhs.uk/personalisedcare/pcsp/), which may include an advance care plan (https://www.england.nhs.uk/publication/universal-principles-for-advance-care-planning/). A hospital discharge is an important opportunity to help the individual review and update their advance care plan if they wish to, or to initiate advance care planning conversations. Such conversations must be ongoing with options regularly reviewed, revisited and revised beyond discharge.

Health and care providers from across statutory and voluntary and community sectors (including hospices) should collaborate to minimise common issues that may disrupt the provision of care as part of the discharge process. This may include consideration of:

- anticipatory prescribing
- access to medication and trained professionals to administer them where necessary
- appropriate equipment (such as a hospital bed)
- 24-hour nursing care
- allied health professionals (such as occupational therapy)

Health and care professionals should also be aware of 'Special Rules' for end of life (https://www.gov.uk/government/publications/dwp-factual-medical-reports-guidance-for-healthcare-professionals/the-special-rules-how-the-benefit-system-supports-people-nearing-the-end-of-life) and support applications for

those who are eligible. The important role played by unpaid carers, including when they are an integral part of the personalised care and support plan, and the need for carers' breaks and for carers' support is clearly set out in the national framework for NHS continuing healthcare and NHS-funded nursing care.

Following discharge, people receiving palliative or end of life care should be given appropriate and compassionate support to enable them to continue living as well as possible. NHS bodies and local authorities have a duty to co-operate to provide appropriate rehabilitation and/or reablement support, which may include support from palliative and end of life care services, to maximise the individual's independence or meet other personal goals.

Effective and timely discharge is of particular importance for people who have been recognised by an appropriate clinician as having a primary health need arising from a rapidly deteriorating condition and who may die within days or weeks. This should be possible whenever necessary, including out of hours. ICBs should have regard to the national framework for NHS continuing healthcare and NHS-funded nursing care, including the Fast-track pathway tool for NHS continuing healthcare (https://www.gov.uk/government/publications/nhs-continuing-healthcare-fast-track-pathway-tool), while also considering key requirements of access to medication and trained professionals to administer them, appropriate equipment, hands on nursing by paid or unpaid carers, support from allied health professionals and access to specialist palliative care advice when required.

11. Information should be shared across relevant health and care teams and organisations across the system in a secure and timely way to support best outcomes

One of the purposes of integrating health and social care is to ensure smoother care pathways with care joined up around a person's life, needs and wishes, including an individual's information and data being shared between relevant organisations with their consent. Relevant care information should be discussed and communicated in a timely manner to the individual and the people and services who will provide onward care support, such as intermediate care services, domiciliary care teams, community health services, care homes, GPs, unpaid carers, independent advocates and family members.

Health and care professionals (such as clinicians and social workers) should share appropriate and accurate information early to support a safe and timely discharge, for example, about medication (including whether

medication has changed since hospital admission) and immediate support needs, including transport and equipment required. They should also seek information from those involved in the patient's care prior to admission early on so this can be used to inform discharge planning.

Sufficient and accurate information should be provided on discharge to enable any providers of onward care and support to meet the needs of the person transferred to them. This includes details about the person's condition, information about the person's medications, whether a personalised care and support plan or personal wellbeing plan has been updated or established, and arrangements to have their care and support regularly reviewed to support their recovery.

Health and care professionals should share key information about an individual's communication needs (for example, if they have a learning disability or dementia), specific care preferences and details about their unpaid carer or family member. There is an opportunity to ensure that the unpaid carer is identified on the person's health and care record as well as their own health and care record. If an individual experiences substantial difficulty in communicating their needs and does not have a friend or family member to support them, an independent advocate must be instructed.

Local areas should have information sharing protocols and mechanisms to enable data about the discharge process to be shared in a timely and effective manner to facilitate safe and timely discharges. This could include developing a shared dashboard of key activity and performance metrics, which would provide accurate information to underpin service and management decisions. Through care transfer hubs, multidisciplinary teams should make use of the Capacity Tracker to identify services that can support a person's discharge. The searchable database of vacancies includes CQC registered care home, community rehabilitation, substance misuse and hospice locations.

12. Planning and implementation of discharge should respect an individual's choices and provide them with the maximum choice and control possible from suitable and available options

The NHS Act 2006 sets out the general duty as to patient choice on NHS England. These include a requirement on relevant bodies to 'act with a view to enabling patients to make choices'.

During discharge planning conversations people with new or additional needs may be offered choices of short-term health and/or social care and support in the community to aid their post-discharge recovery. The choices

offered will depend on what has been put in place locally and should be suitable for a person's short-term recovery needs and available at the time of discharge. It is recommended that choice is provided where possible for such services, and NHS bodies should have regard to the NHS Choice Framework (https://www.gov.uk/government/publications/the-nhs-choice-framework).

Early and ongoing discharge planning conversations between healthcare professionals and people and their families and unpaid carers, following the principles of personalised care, are key to enabling choice while preventing delays. These conversations should be facilitated through care transfer hubs as part of early discharge planning where appropriate.

People should be supported to participate actively in making informed choices about their care, including, for people who fund their own care, the potential longer-term financial impact of different care options after discharge. These conversations should begin early as part of discharge planning and not wait until the person is ready to be discharged. This should include, where appropriate, information about housing options (adaptation of the existing home and possible alternative housing, for example supported living).

Where there is disagreement between a person and their unpaid carers or family members, and the appropriate professional has no reason to consider that the person lacks capacity to make decisions relevant to their discharge, then the matter will need to be resolved, hopefully through informal agreement.

Where an individual wishes to return home and their family member or unpaid carer is unwilling or unable to provide the care needed, NHS bodies, local authorities and care providers should work together to assess and provide the appropriate health and social care provision required to facilitate the individual's choice, where possible, and enable a safe discharge. Capacity Tracker can be used to support choice by identifying available services.

If a person does not accept a short-term package or temporary placement from the options offered, following discussion they should be discharged to an alternative that is appropriate for their short-term recovery needs. People do not have the legislative right to remain in a hospital bed if they no longer require care in that setting, including to wait for their preferred option to become available. Those on the discharge to assess pathway should be discharged to a temporary care home placement for an assessment of long-term or ongoing needs, after which the decision about their permanent care home placement should be made.

Local authorities should also remember that the regulations and guidance on choice of accommodation and additional costs apply equally to:

- those entering care for the first time
- those who have already been placed by a local authority
- those who have been self-funders, but because of diminishing resources are on the verge of needing local authority support

If the assessment determines that the person has eligible needs under the Care Act 2014, the local authority must ensure that the person has a genuine choice of accommodation as set out in the Care and support statutory guidance.

While NHS organisations are recommended to offer choice to patients where possible, in practice there may be limited situations where an NHS organisation has to limit the choice of services offered to people on discharge. This may include times of extreme operational pressures - for example, if a level 4 (national) incident is declared. A record should be produced of the considerations of the relevant discharging body in deciding to limit the choices available to a patient, setting out all the material considerations for and against doing so, and the balancing exercise between the patient choice duty in the NHS Act 2006, and relevant competing duties and countervailing factors.

13. Mental capacity, advocacy and special arrangements for discharge

Some people with advanced dementia, autism, learning disabilities and acquired brain injury, among other groups, are assessed to ‘lack the mental capacity’ to make specific decisions about their own lives. Their rights are protected by the Mental Capacity Act 2005.

Mental capacity is decision-specific and time-specific and assessments should not be of their ability to make decisions generally. If there is a reason to believe a person may lack the mental capacity to make relevant decisions about their discharge arrangements at the time the decisions need to be made, a capacity assessment should be carried out as part of the discharge planning process. Where the person is assessed to lack the mental capacity to make a relevant decision about discharge, any best interests decision must be made in line with the Mental Capacity Act.

No one who lacks the relevant capacity should be discharged to somewhere assessed to be unsafe, and the decisionmaker who makes the best interests decision should make a record of the decision. Further information about making decisions under the Mental Capacity Act can be found in the Mental Capacity Act: making decisions

(https://www.gov.uk/government/collections/mental-capacity-act-making-decisions) document collection.

Capacity assessments and best interests decisions must consider the available options. Onward care and support options which are not suitable (for example, those not considered clinically appropriate) or available (for example, placements which are not available) at the time of hospital discharge cannot be considered in either mental capacity assessments or 'best interests' decision-making.

Just as a person with the relevant capacity does not necessarily have a legislative right to remain in an acute or community hospital bed if they no longer require care in that setting, neither is this an option for a person who lacks the mental capacity to make relevant decisions about discharge.

In certain circumstances during discharge planning, health and care providers might determine that someone is, or will be, 'deprived of their liberty' because of the proposed arrangements for their care and treatment. In these circumstances, decisionmakers must comply with the legal requirements regarding the person's right to liberty (Article 5 of the European Convention on Human Rights).

For adults residing in a care home or hospital, this would usually be provided by the Deprivation of Liberty Safeguards (DoLS). This includes carrying out a capacity assessment and a best interest assessment before a decision about discharge to a care home is made, if there is reason to believe a person may lack the mental capacity to consent to their discharge arrangements which amount to a deprivation of liberty.

Any decision by the decisionmaker must be taken specifically for each person and not for groups of people. The Deprivation of Liberty Safeguards - Code of Practice (https://webarchive.nationalarchives.gov.uk/ukgwa/20130104224411/http:/www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_085476) sets out guidance in relation to DoLS and deprivation of liberty. The starting point should always be to consider whether the restrictions can be minimised or removed, so that the person will not be deprived of liberty.

In some cases, it may be appropriate for an independent advocate to support an individual during the discharge planning process, and this may be a legal requirement. Advocates are independent from the NHS and local authority and are trained to help people understand their rights and options, express their views and wishes, and help make sure their voice is heard. Advocates play a vital role for people including, but not limited to, people with a learning disability, dementia, acquired brain injury or people currently lacking capacity to make decisions about their mental health treatment.

Referrals to independent advocacy services should be made as soon as discharge planning begins and ideally upon admission, or where there is a

legal duty to provide an independent mental capacity advocate (IMCA) as soon as the legal criteria applies.

If there is a deputy or attorney with authority to make relevant decisions about discharge, then that individual is the best interests decisionmaker for the purposes of the Mental Capacity Act 2005.

14. NHS bodies and local authorities should ensure people receive support that is tailored to their specific needs and circumstances

Where there are ongoing health, housing or social care needs after discharge with different care options available, individuals (and, where relevant, their family, unpaid carers or advocates) should be empowered and supported to make the best choice for their individual circumstances.

Care transfer hubs should incorporate appropriate safeguards for individuals who require onward care and support. For example, people who are experiencing homelessness, are at risk of homelessness, are living in poor or unsuitable housing, or who have a drug or alcohol dependency should be determined as such on admission to hospital. Individuals with a physical or learning disability and mental health needs have an increased probability of needing to use the social care system in their lifetime.

Local areas should ensure that all legal responsibilities are met in relation to after care in section 117 of the Mental Health Act 1983. There is separate guidance for discharge from mental health hospitals (https://www.gov.uk/government/publications/discharge-from-mental-health-inpatient-settings), which includes guidance on how budgets and responsibilities should be shared to pay for section 117 after care of the Mental Health Act.

Health and social care professionals should follow an ongoing commitment to reducing health disparities and inequalities and consider the needs of groups that might need specialised support. This includes, but is not limited to, understanding issues relevant to people from black, Asian and minority ethnic groups, people who identify as LGBTQI, faith or cultural needs, people living with disabilities, autistic people, older people, unpaid carers, people who do not speak English, and those with specific communication needs.

Any local changes to discharge arrangements should ensure that care providers are continuing to meet their responsibilities regarding the DoLS. This is especially the case for, but not limited to, people with a learning disability, dementia, acquired brain injury or people with mental health

problems who need to be deprived of liberty in hospital or in care home accommodation.

For people where new mental health concerns have arisen, case managers should contact psychiatric liaison teams in the first instance to review and assess as appropriate. A care co-ordinator or relevant mental health clinician should be involved in the discharge planning for people with a pre-existing mental health concern who are known to mental health services, to ensure their mental health needs are considered. They should ensure that the proposed onward care provider, if relevant, is fully aware of the person's support needs.

For those who are being discharged from acute or community settings following an episode of self-harm, the provider should consult NICE guidelines to ensure appropriate processes are being followed (see Transition between inpatient hospital settings and community or care home settings for adults with social care needs (https://www.nice.org.uk/guidance/ng27)). Where individuals present with mental distress but do not meet the criteria for secondary mental health services, a preventative mental health offer should be available, for example signposting to services such as a provider of local NHS talking therapies.

NHS trusts should identify at the point of admission anyone who is experiencing homelessness or threatened with homelessness. They should refer the person to the relevant local authority homelessness or housing options teams as early as possible during their stay, under the requirements of the Homelessness Reduction Act 2017, if the person consents. This duty to refer ensures services are working together effectively to prevent homelessness by ensuring people's housing needs are considered when they come into contact with public authorities.

People who are experiencing homelessness or at risk of homelessness should not be excluded from short-term post-discharge recovery and support because of their housing status. Further guidance on supporting people who are experiencing homelessness when being discharged from hospital can be found in the Local Government Association (LGA) and the Association of Directors of Adult Social Services (ADASS) high impact change model for managing transfers of care (https://www.local.gov.uk/our-support/partners-care-and-health/care-and-health-improvement/working-hospitals/managing-transfers-of-care) and the accompanying support tool.

For people living in poor or unsuitable housing, the local housing authority has a duty to provide any necessary adaptations (as determined by legislation and regulations underpinning the Disabled Facilities Grant System) and assess housing needs. The local authority also has the power to implement fast-track and integrated systems for such provision.

Many people admitted to acute medical units have a condition which makes them frail[footnote 6]. This is characterised as multiple physical, cognitive and

functional impairments resulting in longer stay in hospital and higher rates of hospital-acquired harms such as deconditioning, falls, infection, delirium and adverse drug events. Research suggests that the average 30-day readmission rates are around 20% in this group, but many can be prevented by comprehensive geriatric assessment and discharge planning that includes a specific focus on:

- medicines reconciliation and optimisation
- patient and carer information, advice and support
- falls interventions
- provision of assistive technology to mitigate risk at home

The default pathway for people with frailty should be home first, with recovery support at home to regain functional ability after discharge. However, some people with more severe frailty may require a period of step-down bed-based care to support them to recover and/or regain confidence, maximising independence and delaying progression to long-term residential care.

Glossary of terminology

Care transfer hub

A physical and/or virtual co-ordination hub or single point of access whereby all relevant services across sectors (such as health, social care, housing and the voluntary and community sector) are linked together to co-ordinate health and/or social care and support to aid timely and person-centred discharge and recovery.

Case manager

A health and/or social care professional assigned to a person being discharged through the care transfer hub to support the person’s discharge and recovery.

Criteria-led discharge

A process by which clear clinical criteria for safe discharge are documented for selected patients that can be enacted by an appropriate junior doctor, nurse or allied health professional without further consultant review. Not all patients awaiting discharge will be suitable for criteria-led discharge, with most patients suitable fitting into discharge pathways 0 or 1.

Criteria to reside

Criteria to aid clinical decision-making in relation to discharge from acute hospitals. The criteria specify parameters that require a person to reside in an acute hospital bed. Acute hospital inpatients should be reviewed twice daily and those who do not meet the criteria to reside must be actively considered for discharge.

Discharge to assess (D2A)

A model whereby people with new or additional health and/or social care needs on discharge receive post-discharge recovery support, and where assessments of longer-term or ongoing needs (if required) are fully completed only once a person has reached a point of recovery and stability. As discharge to assess is underpinned by simple principles rather than rigid criteria, there is no fixed delivery model.

Executive lead

An executive employed by any partner in the system to provide strategic oversight of the discharge process. The executive lead oversees the single co-ordinator.

Home first

An approach whereby supporting people to be discharged home is the default discharge pathway, with alternative pathways for people who cannot go straight home. This principle is a key part of the discharge to assess model.

Integrated care board (ICB)

A statutory NHS body, with its own leadership team, responsible for commissioning healthcare services across a geographical area. The Health and Care Act 2022 transferred the responsibilities of clinical commissioning groups to integrated care boards.

Integrated care partnership (ICP)

A statutory committee, established jointly by each integrated care board and the local authority or local authorities in its area, responsible for developing an integrated care strategy for a geographical area.

Integrated care system (ICS)

A partnership of NHS organisations, local authorities and other health and care partners who work together to provide integrated care, improve health outcomes and reduce health inequalities across a defined geographical area. There are 42 integrated care systems across England and each is made up of 2 components: an integrated care board and an integrated care partnership.

Intermediate care

Home or community bed-based services provided for a short period of time to people after they are discharged from hospital or a virtual ward, or when they are at risk of being admitted to hospital. Includes community rehabilitation and reablement services delivered by health and/or social care professionals. Intermediate care helps people to regain function following illness or injury (rehabilitation) and regain skills and confidence to do things for themselves (reablement) thus maximising independent living.

Local areas

Collective term for NHS bodies (including ICBs, NHS trusts and NHS foundation trusts) and local authorities exercising functions in England, in each ICS area.

Multidisciplinary hospital discharge team

A group of health and care staff who are members of different organisations and professions (for example, GPs, social workers, nurses), that work together to make decisions regarding the discharge of patients from hospital and their immediate care arrangements.

Ongoing care

The term used for a person's longer-term care following a period of recovery post-discharge.

Onward care

The term used for recovery services immediately post-discharge from an NHS acute hospital, NHS community hospital or NHS virtual ward.

Personalised care

Care that is planned and delivered in collaboration with people giving them choice and control based on what matters to them and their individual strengths and needs. Personalised care comprises 6 key components:

- shared decision-making
- personalised care and support planning
- patient choice

- social prescribing and community-based support
- supported self-management
- personal health budgets

Each component has an important role to play in ensuring people are discharged successfully.

Single co-ordinator

A leader employed by any partner in the system to act on behalf of the system to ensure safe and timely discharge on the appropriate pathway for all individuals. The single co-ordinator is accountable to the executive lead.

Trusted assessor

A qualified professional acting on behalf of, and with the permission of, a social care provider to carry out a holistic assessment of a patient's post-discharge health and care needs

Unpaid carers

All family members, friends and others who are providing unpaid care to the person being discharged. This includes (but is not limited to) adult carers, young carers, young adult carers and parent carers.

Virtual wards

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

Related guidance and useful links

This guidance should be read alongside the 2015 NICE guidance Transition between inpatient hospital settings and community or care home settings for adults with social care needs (https://www.nice.org.uk/guidance/ng27).

Other relevant documents include:

- Quick guide: discharge to assess (PDF, 862KB) (https://www.nhs.uk/nhsengland/keogh-review/documents/quick-guides/quick-guide-discharge-to-access.pdf) - NHS England and ADASS
- CQC guidance on trusted assessors (PDF, 185KB) (https://www.cqc.org.uk/sites/default/files/20180625_900805_Guidance_on_Trusted_Assessors_agreements_v2.pdf)
- ADASS snap survey findings (https://www.adass.org.uk/adass-new-rapid-survey-findings)
- Still Hidden Still Ignored - Who cares for young carers? (https://www.barnardos.org.uk/research/still-hidden-still-ignored-who-cares-young-carers) - Barnardo's
- Managing transfers of care - A High Impact Change Model (https://www.local.gov.uk/our-support/our-improvement-offer/care-and-health-improvement/systems-resilience/refreshing-high) - LGA
- Community health and care discharge and crisis care model: an investment in reablement (https://www.local.gov.uk/publications/community-health-and-care-discharge-and-crisis-care-model-investment-reablement) - LGA
- Why not home? Why not today?' reducing length of stay action cards (https://www.england.nhs.uk/publication/why-not-home-why-not-today-reducing-length-of-stay-action-cards/) - NHS England
- People first: manage what matters (https://www.local.gov.uk/our-support/partners-care-and-health/care-and-health-improvement/people-first-manage-what-matters) - Newton Europe publications
- Statutory guidance on working together to safeguard children (https://www.gov.uk/government/publications/working-together-to-safeguard-children--2)
- COVID-19 emergency preparedness, resilience and response (EPRR) acute and community daily discharge situation reports (SitReps) (https://www.england.nhs.uk/publication/covid-19-eprr-acute-and-community-daily-discharge-situation-reports-sitreps/) - NHS England
- Improvement guidance for writing a criteria-led discharge policy (https://www.england.nhs.uk/publication/improvement-guidance-for-writing-a-criteria-led-discharge-policy/) - NHS England

- Effective commissioning for a home first approach (PDF, 375KB) (https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2022/03/B1412_iii-annex-b-RSM-effective-commissioning-for-a-homefirst-approach.pdf) - NHS England

LGA and ADASS have produced 2 ‘top tips’ guides:

- Top tips guidance on implementing a home first approach to discharge from hospital (PDF, 868KB) (https://www.local.gov.uk/sites/default/files/documents/LGA-ADASS%20Home%20First%20Top%20Tips%20February%202021%20WEB.pdf)
- Top tips guidance on implementing a collaborative commissioning approach to home first (https://www.local.gov.uk/our-support/our-improvement-offer/care-and-health-improvement/integration-and-better-care-fund/hospital-discharge/guidance/top-tips)

Annex A: discharge to assess - operational process

Where somebody is admitted to hospital for elective treatment their likely short-term care needs upon discharge should be considered and discussed with them prior to their admission. A provisional plan should be put in place at this point, including what support will be available from family and friends, so that they are able to prepare for the discharge prior to admission.

Where somebody has been admitted to hospital as an emergency admission, their likely short-term care needs on discharge should be considered as soon as possible after their admission. It is good practice to set an estimated date of discharge and destination (type of setting) within 48 hours of admission. This should be discussed with and communicated to the patient, family, unpaid carers and care home (if that is the normal place of residence).

Where a patient is likely to need an interim package of care on leaving hospital, pending any assessment of their longer-term care needs, the relevant care transfer hub should ensure that a multidisciplinary team assesses the appropriate discharge pathway (type of setting) and any immediate support the person will need on being discharged, including any issues relating to safeguarding and housing. This will include confirming any immediate home-based support required, for instance support from voluntary and community sector organisations to make their home suitable for discharge and/or social care packages of support, or any specific risk issues and support needs if being discharged to a bedded setting.

The assessment should be dynamic and subject to revision as the patient continues to recover while in hospital, keeping the best interests and outcomes for the individual at the centre of decision-making. Post-discharge needs should be discussed with patients, their family and carers, in line with the legal duty to involve patients and unpaid carers in discharge planning as soon as feasible. All practical assistance should be made available to encourage and support the person to make decisions for themselves.

Before a patient is discharged, the multidisciplinary team and care transfer hub should confirm the discharge pathway and a prescription for the immediate support needed. The care transfer hub should make final arrangements to ensure a smooth and timely transfer of care.

Hospitals should consider patients' recovery and support needs from the point they are admitted or, in the case of elective patients, prior to admission, and take appropriate steps to prevent avoidable deconditioning while they are in hospital. Where patients need short-term therapy-led rehabilitation, reablement and/or recovery support following discharge, these needs should be identified as soon as possible in hospital.

Depending on the patient's circumstances, it may be appropriate - and may support timely discharge - to make final decisions on the precise nature of any post-discharge support and arrange that support shortly after the patient has left hospital. Where this is the case, the decision about where to discharge the patient to should take account of which provider is best placed to meet their rehabilitation, reablement and/or recovery needs.

The 'assess' part of discharge to assess refers to Care Act assessments carried out to determine the long-term health and social care needs of a person and the eligibility of their needs for care and support. Assessments of longer-term care needs (including Care Act assessments) should take place after someone has left hospital and after an initial period of recovery. In the case of continuing healthcare assessments, it is best practice to screen at the right time and in the right place for that individual. In most cases this will be following discharge and after a period of recovery.

Annex B: discharge pathways

Pathway 0

Simple discharge home (to usual place of residence or temporary accommodation) co-ordinated by the ward without involvement of the care

transfer hub, with:

- no new or additional health and/or social care and support
- self-management with signposting to services in the community
- voluntary sector support
- re-start of pre-existing home care package at the same level that remained active and on pause during the person's hospital stay
- returning to original care home placement with care at the same level as prior to the person's hospital stay[footnote 7]

Pathway 1

Discharge home (to usual place of residence or temporary accommodation) with health and/or social care and support co-ordinated by the care transfer hub, including:

- home-based intermediate care on a time-limited, short-term basis for rehabilitation, reablement and recovery at home
- re-start of home care package at the same level as a pre-existing package that lapsed
- returning to original care home placement with time-limited, short-term intermediate care
- long-term care and support at home following a period of intermediate care in the community

Pathway 2

Discharge co-ordinated through the care transfer hub to a community bedded setting with dedicated health and/or social care and support, including bed-based intermediate care on a time-limited, short-term basis for rehabilitation, reablement and recovery in a community bedded setting (bed in care home, community hospital or other bed-based rehabilitation facility).

Pathway 3

In rare circumstances, for those with the highest level of complex needs, discharge to a care home placement co-ordinated through the care transfer hub, including:

- care home placement for assessment of long-term or ongoing needs and facilitation of patient choice in relation to the permanent placement
- long-term care and support in a care home following a period of intermediate care in the community

Annex C: specific responsibilities related to discharge processes

The following sections summarise specific responsibilities and best practice for NHS bodies, local authorities and care providers to follow when planning and delivering discharge services.

Commissioners of health and care services

Commissioners of health and care services should work in partnership to:

- agree clear commissioning arrangements for onward health and social care and support services for people who are discharged with clear agreement on who is responsible for paying for the care, including the use of pooled funding arrangements where appropriate
- provide adequate health and social care discharge services, operating 7 days a week
- plan and commission sufficient provision to meet the needs of the population
- co-ordinate local financial flows for post-discharge care and support, including monitoring all local spend and co-ordinating local funding arrangements
- agree commissioning arrangements for community palliative and end of life care services, optimising the best use of all available financial resources including those currently allotted to continuing healthcare fast-track and 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
- promote the use and development of effective tracking tools for care homes, hospices and community rehabilitation providers, using

domiciliary and residential capacity trackers to support discharge planning, and monitoring the effectiveness of reablement and rehabilitation

- work with system partners to ensure appropriate data collection and use data to improve outcomes for individuals
- give clear information to providers on which contract will be used, for example, NHS commissioning bodies must use the NHS Standard Contract (https://www.england.nhs.uk/nhs-standard-contract/previous-nhs-standard-contracts/22-23/)

Local authorities

Local authorities should:

- as outlined in the Care Act 2014, take the lead on shaping the local care market, for example, expanding local capacity in domiciliary care and reablement services and developing long-term provision with surge capacity for periods of additional pressure
- work with CQC 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, where needed, for people being discharged
- agree a single point of contact for each local health and care system, ensuring each acute trust and single co-ordinator has a single point within the local authority to approach when planning discharge for people living in that local authority area
- work with partners to co-ordinate activity with local and national voluntary and community sector organisations to provide services and support to people requiring support around discharge and subsequent recovery
- carry out an assessment in respect of young carers upon request or appearance of need, considering whether it is appropriate or excessive for the young carer to provide care

Local authority adult social care teams should:

- identify an executive lead for the leadership and delivery of discharge processes
- make provision for Care Act assessments of need, financial assessments and longer-term care planning to take place following discharge, ensuring a seamless transition from short-term recovery support to longer-term ongoing support

- ensure expert social work professionals can contribute to hospital based multidisciplinary discussions and decision-making before discharge
- ensure social care expertise is a central part of the process to work with people to determine their long-term care needs following a period of recovery and ensure people are fully aware of their options and the implications of each option
- continue to conduct safeguarding activities in a hospital setting if necessary
- review care provision and, where necessary, make changes in line with good practice and legal responsibilities
- assess whether an unpaid carer needs support (or is likely to do so in the future) and, if the unpaid carer does, what those needs are (or are likely to be in the future)
- support real time communication between the acute and community settings and the single co-ordinator, not just by email
- work with NHS bodies to ensure appropriate data collection and use data to improve outcomes for individuals
- make use of the Capacity Tracker to identify available services when appropriate

Adult social care providers

Adult social care providers should:

- work in collaboration to plan and monitor local capacity to ensure there is appropriate social care support in place to support effective discharges
- where possible, support 7-day working for community social care teams (commissioned by local authorities) and other care provision
- deploy adult social care staff flexibly to support best outcomes for people, including providing any support needed to avoid immediate bottlenecks in arranging step-down care and support in the community and helping develop capacity to meet local needs
- provide feedback on discharge commissioning and contracting arrangements and, where necessary, seek improvements
- be aware of where they must provide data with regards to the adult social care provider information provisions: data collection statutory guidance (https://www.gov.uk/government/publications/adult-social-care-provider-information-provisions-data-collection/adult-social-care-provider-information-provisions-guidance-for-providers-on-data-collection#annex-a-reporting-window-periods-until-september-2023)

Acute health providers

Hospital ward and discharge teams

Hospital ward and discharge teams should:

- begin discharge planning at, or before, admission
- identify from the outset who a person wishes to be involved and/or informed in discussions and decisions about their discharge
- check whether a personalised care and support plan or personal wellbeing plan and/or a personal health budget, personal budget or integrated personal budget is in place and use it to inform discharge planning (where it is in place) and consider offering it (where it is not in place)
- ensure patients and carers (including young carers) are involved at the earliest opportunity in discharge planning for adult patients who are likely to need care and support following discharge
- follow a criteria-led discharge approach for selected patients
- conduct a twice daily multidisciplinary team review of all acute hospital inpatients to determine those who no longer meet the criteria to reside in an acute hospital bed (Annex D)
- in conjunction with local care home providers, develop trusted assessment arrangements to facilitate discharges where appropriate
- arrange dedicated staff to support and facilitate discharge, including:
  - ensuring transport for people to return home from hospital, where possible and appropriate through family or carers, the voluntary sector or taxi or, only as a last resort, non-emergency patient transport services (NEPTS)
  - working with local voluntary and community sector and volunteering groups to ensure people are supported (where needed) actively for the first 48 hours after discharge
  - ensuring people and any family members, unpaid carers and providers of onward care and support have full information about the next steps of care and are given discharge information which includes medication instructions and safety netting arrangements
  - ensuring ‘settle in’ support at home is provided where needed
  - ensuring required medication and essential equipment are provided at the point of discharge

Hospital clinical and managerial leadership teams

Hospital clinical and managerial leadership teams should:

- create safe and comfortable discharge spaces for people to be transferred to from all ward areas
- ensure the timely transfer of high-quality information to primary care and all other relevant health and social care professionals and providers for all people discharged
- ensure senior clinical staff are available to provide clinical advice to ward and discharge staff and support appropriate risk management
- engage with commissioning bodies and regional colleagues to support clinical leaders in implementing effective discharge processes and setting the right culture for effective approaches to discharge
- closely monitor discharge performance data to ensure discharge arrangements are operating effectively and safely across the system, including over 7 days, and that a high proportion of people on the discharge list achieve a same-day discharge to the most suitable destination for their needs
- ensure that, as part of daily ward rounds, timely and accurate data is collected and submitted via the Acute Daily Discharge Situation Report and Community Daily Discharge Situation Report, so that this is a clinically driven data collection
- ensure that all relevant agencies have access to a live list of those ready for discharge and the delay reasons for those not yet able to be discharged

Community health service providers

Community health service providers, working closely with other system partners, should:

- have an easily accessible contact within the care transfer hub who will accept referrals from staff and source the care requested, in conjunction with local authorities
- take part, as required, in performing the initial holistic safety and welfare check on the day a person goes home
- support a person’s rehabilitation and/or reablement in their own home or a community bed-based setting and facilitate step-down of recovery support from a community bed-based setting to a home setting where appropriate
- monitor the effectiveness of rehabilitation and reablement, working with local authorities as appropriate
- ensure the provision of community equipment to support discharge as required
- take part in assessing the longer-term or ongoing needs of an individual as required, in conjunction with local authorities, ensuring a seamless

transition from short-term recovery support to longer-term or ongoing support

- collect and submit data on the delivery of services to the Community Services Data Set (CSDS)
- use the Capacity Tracker to identify the bed capacity in community rehabilitation bed providers

Annex D: 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 greater than 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 or community care provision?
- last hours of life?
- requiring intravenous medication > b.d. (including analgesia)?
- undergone lower limb surgery within 48 hours?
- undergone thorax-abdominal/pelvic surgery with 72 hours?
- within 24 hours 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 and challenge questions for the clinical team
Is the person medically optimised? Do not use ‘medically fit’ or ‘back to baseline’.

What management can be continued as ambulatory, for example heart failure treatment?

What management can be continued outside the hospital with community/district nurses? For example, IV antibiotics?

Persons with low NEWS (0 to 4) scores - can they be discharged with suitable follow up?

- if not scoring 3 on any one parameter - for example, 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 or 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?

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1. Kortebein P, Symons TB, Ferrando A and others. Functional impact of 10 days of bed rest in healthy older adults. J Gerontol A Biol Sci Med Sci. 2;63:1076-1081 (2008)

2. 1. In NICE guideline Supporting adult carers (https://www.nice.org.uk/guidance/ng150/chapter/Recommendations), section 1.2.7 states that practitioners involved in transferring people to and from hospital should seek to identify carers and refer them to appropriate services. In NICE guideline Transition between inpatient hospital settings and community or care home settings for adults with social care needs (https://www.nice.org.uk/guidance/ng27/chapter/Recommendations), follow guidance in section 1.4, ‘Support for families, parents and carers throughout admission’, and section 1.5, ‘Discharge from hospital’.

3. The NHS Safeguarding App (https://www.myguideapps.com/admin/projects/safeguarding_2021/default/) is available as a free resource and aims to keep you updated on safeguarding and trauma-informed practice (levels 1 and 2). Further information on safeguarding can be found in the following documents published by the Royal College of Nursing: Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff (https://www.rcn.org.uk/professional-development/publications/pub-007366) and Looked After Children: Roles and Competencies of Healthcare Staff (https://www.rcn.org.uk/professional-development/publications/rcn-looked-after-children-roles-and-competencies-of-healthcare-staff-uk-pub-009486) and Adult Safeguarding: Roles and Competencies for Health Care Staff (https://www.rcn.org.uk/professional-development/publications/pub-007366).
4. Rosman, M, Rachminov, O, Segal, O, and Segal, G. Prolonged patients' In-Hospital Waiting Period after discharge eligibility is associated with increased risk of infection, morbidity and mortality: a retrospective cohort analysis (2015). BMC health services research, 15(1), 1-5. Tess, BH, Glenister, HM, Rodrigues, LC, and Wagner, MB. Incidence of hospital-acquired infection and length of hospital stay (1993). European Journal of Clinical Microbiology and Infectious Diseases, 12(2), 81-86.
5. Kortebein, P, Symons, TB, Ferrando, A, Paddon-Jones, D, Ronsen, O, Protas, E and Evans, WJ. Functional impact of 10 days of bed rest in healthy older adults (2008). The Journals of Gerontology Series A: Biological Sciences and Medical Sciences, 63(10), 1076-1081.
6. Conroy S, Dowsing T. The ability of frailty to predict outcomes in older people attending an acute medical unit (2013). Acute Med 12(2):74–6
7. Note, the Acute and Community Daily Discharge SitRep data collections require those returning to their original care home placement to be categorised as pathway 3. However, as they are returning to their home or usual place of residence the data should be disaggregated locally so they are counted as pathway 0 (if returning to receive care at the same level as prior to the person's hospital stay) or pathway 1 (if returning to receive time-limited, short-term intermediate care). The data collections will be amended in line with the policy in due course.