COVID-19 Hospital Discharge Service Requirement

It is vital that we urgently free up as many NHS beds as possible, through faster rates of appropriate discharge. This will save lives.

This document outlines how your role will alter in line with the overarching discharge framework.

Key messages for all staff

- Once someone no longer meets the clinical criteria to require inpatient care in an acute hospital, they will be discharged **as soon as possible <u>today</u>**, and any further assessment required will be done in a community setting. Discharge to assess will be the default for all patients who require assessment of their care needs. Community health providers will need to set up a single coordinator in each acute centre, accountable to a named Executive Board director.
- You will prioritise time to identify and agree which patients can be discharged home or transferred to a non-acute setting.
- Patients will be discharged from the ward / unit within 1 hour after a medical decision to discharge has been confirmed. Discharge home should be the default pathway. If patients are not able to go home immediately, they will be transferred to a safe place to await discharge, which should happen within 2 hours.

MEDICAL STAFF (DOCTORS)

What will I be able to stop doing?

- **Detailed functional inpatient assessments prior to discharge (describe need not provision).**
- **Making decisions about the care people will need after discharge.**

All patients who no longer meet the clinical criteria to require inpatient care in acute hospitals should be discharged home or to a non-acute setting.

Reviews and discharge co-ordination

- At least twice daily multi-disciplinary review (consultant review at least daily) of all patients in acute beds to agree who no longer meets the clinical criteria to require inpatient care and will therefore be discharged.
- Ensure clear plans in medical notes that include clinical criteria for discharge.
- Request immediate arrangements for discharge with a plan for virtual follow up where needed.
- Limited functional assessments should take place in an acute setting once patients no longer have a medical need for inpatient care. Patients requiring on-going support will be discharged to assess.
- The multi-disciplinary team need to clearly describe the support patients will require when they are discharged or transferred.

Safety netting

- Patient initiated follow up. Give the patients the direct number of the ward they are discharged from to call back for advice. Do not suggest going back to their GP or going to the emergency department.
- If required, telephone patients the following day after discharge to check on them for reassurance.
- If required, call patients after discharge with the results of investigations and their management plan.
- Manage patients virtually in outpatient clinics care under the same team / speciality.
- Request community nursing follow up where appropriate.
- Request GPs to follow up in some selected cases.

Criteria led discharge

- Document clear clinical criteria for discharge that can be enacted by the appropriate junior doctor, qualified nurse or allied health professional without further consultant review.
- Ensure arrangements are in place to contact the consultant directly for clarification about small variances from the documented clinical criteria.

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WARD MANAGER (NURSE IN CHARGE)

What will I be able to stop doing?

- **Detailed functional inpatient assessments prior to discharge (describe need not provision).**

All patients that no longer meet the clinical criteria to require inpatient care in an acute hospital should be discharged home or to a non-acute setting

What do I need to do?

- Ensure at least twice daily multi-disciplinary review (consultant review at least daily) of all patients in acute beds to agree who no longer meets the clinical criteria to require inpatient care in an acute hospital and will therefore be discharged.
- Ensure every patient has a clearly written plan which includes clinical and functional criteria for discharge. Make sure the plan is communicated to all multi-disciplinary team members, the patient and their loved ones.
- Limited functional assessments should take place in an acute setting once patients no longer meet the clinical criteria to require inpatient care in an acute hospital. Patients requiring on-going support will be discharged to assess. The multi-disciplinary team need to clearly describe the support i.e. the discharge to assess pathway patients will require when they are discharged or transferred.
- Liaise with managers of the discharge team for pathway 0 (where the patient is discharged home without any support needs/requirements).
- During every ward round, board round or case discussion ensure the following questions are asked:
  - Does the person require the level of care that they are receiving, or can it be provided in another setting?
  - What value are we adding for the person staying in an acute hospital balanced against the risks of them being discharged home or a non-acute setting?
  - What do they need next and what action is required?
  - ‘Why not home, why not today?’ for those who have not reached a point where long-term 24-hour care is required.
  - If not for discharge today, then when? Ensure there is an expected date of discharge.
  - Can a nurse or allied healthcare professional discharge the patient without a further review if documented clinical criteria are met?

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ACUTE THERAPY TEAMS

What will I be able to stop doing?

- **Detailed functional assessments for discharge.**
- **Equipment ordering for anyone requiring ongoing input.**

A significant part of your work will now be in non-acute settings (mainly in patients' homes)

What will I do differently?

- Limited assessments for discharge will be undertaken within a ward or other hospital environments/designated therapy assessment areas.

Roles could include (this is not an exhaustive list and will depend on individual skillsets):

- A new local coordinator role will direct (for each person) who will take on the case management role and undertake the first assessment at home.
- Acute therapists will assess patients in their own home/usual place of residence at the request of the local coordinator and agree a recovery and support plan with the person including reablement support and/or equipment.
- This will be a trusted assessment which will be accepted by the receiving care provider (agreement as to universal document to be used across acute and community services).

When and where will I do my work?

You may work much more fluidly between the community settings, people's homes and within the acute trust, depending on the capacity demands and constraints during the Level 4 emergency.

Cover will be required over 7 days so you may find your hours of work are adjusted.

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BEDDED REHABILITATION (THERAPIES)

What will I be able to stop doing?

- **Assessments on the acute wards**
- **Detailed functional assessments for discharge.**
- **Equipment ordering for anyone requiring ongoing input.**
- **Assessment and discharge notification processes**

You will need to decrease the overall length of stay to create more bedded capacity to support your local acute trust.

How will I need to work differently with colleagues?

- There will be a named patient coordinator based in the acute hospital who will be liaising directly with your unit to facilitate the transfer.
- There will be an increase in the availability of recovery and support services within the community. They will start quicker and help people to regain autonomy at home.
- The new national 'Capacity Tracker Tool' needs to be updated with your bed status to help manage overall NHS bed capacity.

What will I do differently?

- Start a daily clinical review (10-20mins) of the plan for every patient. Focussing on the key questions; Why not home? What needs to be different? Why not today?
- You will use discharge to assess pathways as a discharge route from community rehabilitation beds.
- You will act as trusted assessor for onward referrals. You should not expect to have to re-do assessments, or to use lengthy referral forms.
- You may need to use technology for outreach and follow up to reduce travel time.
- All equipment and care needs will be assessed within the patient's home using the locally agreed routes.

When and where will I do my work?

- Cover will be required over 7 days so you may find your hours of work are adjusted.
- You may be required to outreach to support your patient home. The local co-ordinator will direct the process.

COVID-19 Hospital Discharge Service Requirement

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SOCIAL CARE

What will I be able to stop doing?

- **Assessment and discharge notification processes**
- **Assessment of needs in the acute setting**
- **Funding panel requests**
- **Attendance at board rounds**

A significant part of your work will now be in non-acute settings (mainly in patients' homes)

How will I need to work differently with colleagues?

- In general, no social care or funding assessments will be undertaken in hospital. Safeguarding investigations should continue to take place in a hospital setting if necessary.
- People will be discharged from hospital as soon as possible. You must act to support this as quickly as possible.
- Accept assessments from hospital therapists and act on their recommendations urgently.
- Most people will be discharged home or to the place they lived prior to hospital admission.
- The choice policy will be suspended so people will be discharged with the first available support package or placement that will meet their immediate needs.
- Review care packages as soon as practical to ensure they continue to appropriate and work with community colleagues to adjust appropriately.
- Undertake assessment for longer-term care needs once the person is in the community and such an assessment is possible.

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CCGS & LOCAL SYSTEM COMMISSIONERS

What will I be able to stop doing?

- **Intensive contract monitoring.**

If your CCG (or relevant Commissioning Support Unit (CSU)) and Local Authority currently commission domiciliary care and care homes in relation to discharge in your locality separately you will establish a single commissioning route with one accountable lead organisation and share performance and other data with regard to your local care providers single relationship management routes.

How will I need to work differently with colleagues?

- You will determine a lead commissioning organisation and lead commissioner.
- The lead commissioner will work closely with the single discharge co-ordinator to ensure that issues in relation to flow through commissioned services are promptly addressed.

What will I do differently?

- You will expand the use of telecare and telehealth where possible.
- Support greater use of personal health budgets and individual service funds to support mainstream care at home, provided by directly employed carers.
- Establish contractual options to maintain continuity of care from providers supporting pathway 1 patients at home when the discharge to assess period of free care is completed.
- Co-ordinate and lead the rapid implementation of the Capacity Tracker.

When and where will I do my work?

- You are likely to work much more closely with people engaged in different elements of the commissioning process from other organisations.
- You are likely to need to work more flexibly to support the new requirements. Cover will be required over 7 days so you may find your hours of work are adjusted.

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MANAGERS OF THE DISCHARGE TEAM

What will I be able to stop doing?

- **The new guidance reduces current requirements to collect and report various forms of activity.**

A significant part of your work will now be co-ordinating care input and oversight in non-acute settings (mainly in patients' homes)

How will I need to work differently with colleagues?

- Effective liaison with wards for pathway 0 (where the patient is discharged home without any support needs/requirements).
- Close collaboration with the new role of Single Co-ordinator for pathways 1,2 and 3.

What will I do differently?

- Ensuring that people are assessed for short term care needs as they arrive home.
- Ensuring assessment and tracking capacity for pathways 1, 2 and 3 to ensure people are tracked and followed up to assess for long term needs at the end of the period of recovery.
- Arranging dedicated staff to support and manage patients on pathway 0.

When and where will I do my work?

- You may work much more fluidly between community settings, and within the acute trust, depending on the capacity demands and constraints during the COVID-19 emergency period.
- Cover will be required over 7 days so you may find your hours of work are adjusted.

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MEMBERS OF THE DISCHARGE TEAM

What will I be able to stop doing?

- **Processing assessment and discharge notices because there will be none.**
- **Arranging discharges of people on pathways 1-3.**

You will continue discharging patients on pathway 0 (straight home with no required support) and a significant part of your work may now be in non-acute settings (mainly in patients' homes).

How will I need to work differently with colleagues?

Staff from discharge teams will be using their skills to supplement capacity in the new discharge to assess service and will be directed by the single co-ordinator role and supported by their line manager.

What will I do differently?

Roles could include (this is not exhaustive and will depend on individual skillsets):

- Case manager in the acute trust (every patient will be allocated a case manager as soon as the decision to discharge is made by the consultant).
- Accompanying patients to the discharge lounge.
- Accompanying patients' home or to another setting when discharged.
- Carrying out reviews and assessments of patients who are on the discharge to assess pathways.
- Acting as trusted assessor for care homes and community beds.
- Other non-clinical roles within the hospital and community as required to support effective flow of patients.

When and where will I do my work?

- You may work much more fluidly between the community settings, people's homes and within the acute trust, depending on the capacity demands and constraints during the COVID-19 emergency period.
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NHS CONTINUING HEALTHCARE NURSE

What will I be able to stop doing?

- **NHS CHC assessments for individuals on the acute hospital discharge pathway and in community settings.**

What do I need to do?

- Re-deploy staff as appropriate to support local business continuity plans.
- Support onward transfer of care for people with complex care needs.
- Identify and commission discharge to assess placements.
- Case management as appropriate.
- Provide support and advice to care homes.
- Proportionate reviews to ensure that individual's care packages are meeting their needs and to ensure that any concerns raised are addressed as appropriate.
- Monitor and track action taken during the COVID-19 emergency period, for example using the NHS CHC Checklist, so that individuals can be identified who may need an assessment once business as usual resumes.

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