



COVID-19 Hospital Discharge Service Requirements

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1. Summary

- 1.1 This document sets out the Hospital Discharge Service Requirements for all NHS trusts, community interest companies and private care providers of acute, community beds and community health services and social care staff in England, who must adhere to this from Thursday 19th March 2020. It also sets out requirements around discharge for health and social care commissioners (including Clinical Commissioning Groups and local authorities).
- 1.2 Unless required to be in hospital ([see Annex B](#)), patients must not remain in an NHS bed.
- 1.3 Based on these criteria, acute and community hospitals must discharge all patients as soon as they are clinically safe to do so. Transfer from the ward should happen within one hour of that decision being made to a designated discharge area. Discharge from hospital should happen as soon after that as possible, normally within 2 hours.
- 1.4 Implementing these Service Requirements is expected to free up to at least 15,000 beds by Friday 27th March, with discharge flows maintained after that. Acute and community hospitals must keep a list of all those suitable for discharge and report on the number and percentage of patients on the list who have left the hospital and the number of delayed discharges through the daily situation report.
- 1.5 The current legislation does not describe a specific timeframe for carrying out NHS CHC assessments of eligibility, or for individual requests for a review of an eligibility decision (i.e. Local Resolution and Independent Review). Therefore, NHS CHC assessments for individuals on the acute hospital discharge pathway and in community settings will not be required until the end of the COVID-19 emergency period. Planned legislative change, as part of the COVID-19 Bill, will further support the NHS in relation to this.
- 1.6 The Government has agreed the NHS will fully fund the cost of new or extended out-of-hospital health and social care support packages, referred to in this guidance. This applies for people being discharged from hospital or would otherwise be admitted into it, for a limited time, to enable quick and safe discharge and more generally reduce pressure on acute services.

1.7 Discharge requires teamwork across many people and organisations and the funding and eligibility blockages that currently exist cannot remain in place during the COVID-19 emergency period. Therefore, a discharge to assess model will be introduced across England.

1.8 The discharge-to-assess model is based on using four clear pathways for discharging patients as shown below

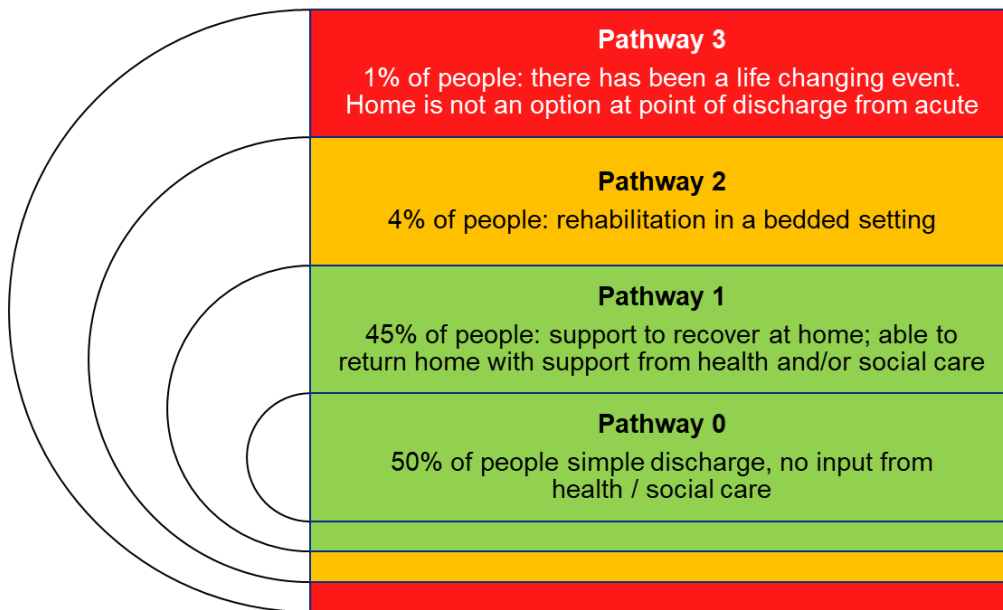
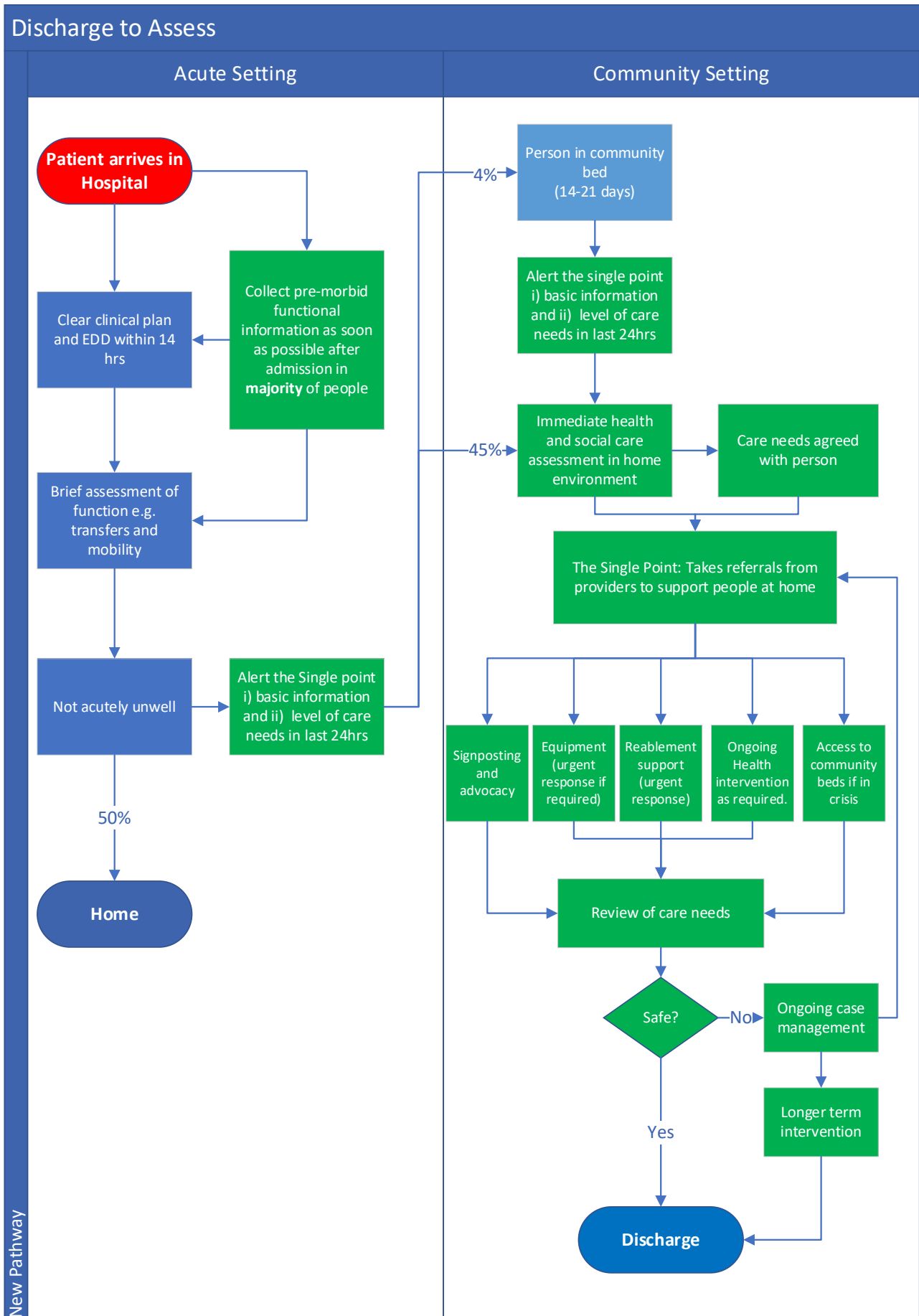


Figure 1: Discharge to Assess model

1.9 Acute hospitals will be responsible for leading on the discharge of all patients on pathway 0, ensuring that the 50% of patients that can leave the hospital and only need minimal support do so on time.

1.10 Providers of community health services will lead on pathways 1-3 as they will play a lead role in assessing and providing care for patients once they are home. Community health providers will need to set up a single coordinator in each acute centre, accountable to a named Executive Board lead in their own organisation, to ensure accountability for delivering the change. The co-ordination team will ensure all patients (irrespective of their address) are discharged on time and are provided with the follow up support as needed. The Discharge Service needs to operate at a minimum 8am-8pm, seven days a week. This approach applies to discharges from all NHS community and acute beds.

- 1.11 The discharge to assess pathways 1-3 will only be successful if NHS organisations work hand in glove with adult social care colleagues, the care sector and the voluntary sector.
- 1.12 Whilst most people will be discharged to their homes, a very small proportion will need and benefit from short or long term residential or nursing home care. The Discharge Service will be able to access live information from a national community bed tracker system. The existing North of England Commissioning Support (NECS) care home tracker will be extended to cover all care home places, all NHS community hospital beds and hospice beds. All providers must sign up and start using the tracker by 23 March 2020 (see Annex F).
- 1.13 The following sections detail what these changes mean for all health and care sectors with a role in hospital discharge and provide clarity on the actions organisations needs to take straightaway. This information will be supplemented by specific action cards outlining how key roles should work differently during this period, which will be published separately and discussed as part of webinar sessions on these changes (see section 12).
- 1.14 There needs to be clear accountability and escalation mechanisms at each stage of the discharge-to-assess process in each locality (see Annex H).
- 1.15 The diagram on the following page describes the discharge to assess process that should be undertaken in acute and community hospitals and once the patient is home.
- 1.16 NHS England and NHS Improvement are grateful for input from The Academy of Medical Royal Colleges and the Association of Directors of Adult Social Services into this guidance.



2. What does this mean for patients?

- 2.1 Patients will still receive high quality care from acute and community hospitals, but will not be able to stay in a bed as soon as this is no longer necessary. For 95% of patients leaving hospital this will mean that (where it is needed), the assessment and organising of ongoing care will take place when they are in their own home. Leaflet A, describing these COVID-19 arrangements, is provided in Annex D and should be shared with all patients on admission to hospital.
- 2.2 On the day a patient is to be discharged patient, (following discussions with the patient, their family and any other professionals involved in their care using leaflets B1/B2 in Annex D), within one hour the ward will arrange to escort the patient to the hospital discharge lounge, so their acute bed can be immediately used by someone being admitted who is acutely unwell.
- 2.3 Within two hours of arriving in the discharge lounge, transport home, any volunteer and voluntary sector support and immediate practical measures, such as shopping and the heating turning on, will be organised by the discharge co-ordinators for those who have no one else to do this.
- 2.4 A lead professional or multidisciplinary team, as is suitable for the level of care needs, will visit patients at home on the day of discharge or the day after to arrange what support is needed in the home environment and rapidly arrange for that to be put in place. If care support is needed on the day of discharge from hospital, this will have been arranged prior to the patient leaving the hospital site, by a care coordinator.
- 2.5 For patients whose needs are too great to return to their own home (about 5% of patients admitted to hospital) a suitable rehabilitation bed or care home will be arranged. During the COVID-19 pandemic, patients will not be able to wait in hospital until their first choice of care home has a vacancy. This will mean a short spell in an alternative care home and the care coordinators will follow up to ensure patients are able to move as soon as possible to their long term care home.
- 2.6 During the COVID-19 pandemic, all of the above support will be paid for by the NHS, to ensure patients move on from their acute hospital stay as quickly as possible.

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

‘Why not home, why not today?’

Acute providers need to rapidly update their processes and ways of working to deliver the discharge-to- assess model.

3.1 Ward level:

- Clinically-led review of all patients at an early morning board round. Any patient meeting the revised clinical criteria will be deemed suitable for discharge
- At least twice daily review of all patients in acute beds to agree who is not required to be in hospital, and will therefore be discharged
- Ensure professional and clinical leadership between nursing, medicine and allied health professions for managing decisions and use prompts in the box below:

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

- All patients who are not required to be in hospital and are therefore suitable for discharge will be added to the discharge list and allocated to a discharge pathway. Discharge home today should be the default pathway
- On decision of discharge, the patient and their family or carer, and any formal supported housing workers should be informed and receive the relevant leaflet (see Annex D).

- Individuals and their families must be fully informed of the next steps
- Transfer off the ward into a discharge lounge within one hour of decision to discharge
- Social care colleagues should be involved in daily ward reviews. This **will** help with the early identification of any possible support, placement or housing issues with discharge and allow the MDT to undertake arrangements in good time.

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

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

3.2 Hospital Discharge Teams:

- Arrange dedicated staff to support and manage all patients on pathway 0. This will include:
 - co-ordinating with transport providers
 - local voluntary sector and volunteering groups helping to ensure patients are supported (where needed) actively for the first 48 hours after discharge
 - 'settle in' support is provided where needed
- Train discharge staff (potentially those who no longer have to undertake CHC assessments) to operate 'Trusted assessments' for patients in hospital from care homes, so they can return to their care home promptly, and support all care homes with these new discharge arrangements.

3.3 Hospital clinical and managerial leadership team:

- Create safe and comfortable discharge spaces for patients to be transferred to within one hour of decision to discharge, ensuring enough space for increased numbers of discharges.
- Maintain timely and high quality transfer of information to General Practice and other relevant health and care professional on all patients discharged.

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- Use change 9 within the High Impact Change Model (see section 12) to ensure planning and discharge for people with no home to go to and that no-one is discharged to the street. See Annex E for further details on homelessness.
- Senior clinical staff to be available to support ward and discharge staff with appropriate risk-taking and clinical advice arrangements
- Where applicable to the patient, COVID-19 test results are included in documentation that accompanies the person on discharge
- Ensure all patients identified being in the last days or weeks of their life are rapidly transferred to the care of community palliative care teams who will be responsible for co-ordinating and facilitating rapid discharge to home or a hospice.

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

4.1 Providers of community healthcare are expected to update their processes and ways of working to deliver the discharge to assess model. Community health services will take overall responsibility for ensuring the effective delivery of the discharge service and for pathways 1,2 and 3. As part of this they should:

- Identify an Executive Lead to oversee the implementation and delivery of the Discharge to Assess model in the acute hospitals in their area. The model should operate at least 8am-8pm 7 days a week
- Release staff from their current roles (see separate Community Health Service prioritisation guidance) to co-ordinate and manage the discharge arrangements for all patients from community and acute bedded units on pathways 1, 2 and 3
- Have an easily accessible single point of contact which will always accept assessments from staff in the hospital and source the care requested, in conjunction with local authorities
- Deliver enhanced occupational therapy and physiotherapy 7 days a week to reduce the length of time a patient needs to remain in a hospital rehabilitation bed
- Use multi-disciplinary teams on the day they are home from hospital, to assess and arrange packages of support for patients on pathways 2 and 3.
- Co-ordinate the care for patients discharged on pathways 1-3
- Ensure provision of equipment to support discharge.
- Ensure patients on all three pathways are tracked and followed up to assess for long term needs at the end of the period of recovery
- Maintain the flow of patients from community beds including re-ablement and rehabilitation packages in home settings, to allow the next sets of patients to be discharged from acute care

4.2 For patients identified being in the last days or weeks of their life Community Palliative Care teams will be responsible for co-ordinating and facilitating rapid discharge to home or hospice. This supersedes the current fast track end of life process

5. What are the actions for Councils and Adult Social Care services?

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

- Agree a single lead local authority or point of contact arrangement for each hospital or Trust, ensuring each acute trust and single local coordinator for local discharge to assess pathways has a single point to approach when coordinating the discharge of all patients, regardless of where that person lives
- Work together and pool staffing to ensure the best use of resources and prioritisation in relation to patients being discharged, respecting appropriate local commissioning routes. During this period, funding will be made available for all patients being discharged and local authorities are enabled by the Care Act (Section 19) to meet urgent needs where they have not completed an assessment and regardless of the person's ordinary residence
- Coordinate work with local and national voluntary sector organisations to provide services and support to people requiring support around discharge from hospital and subsequent recovery
- Take the lead contracting responsibilities for expanding the capacity in domiciliary care, care homes and reablement services in the local area paid for from the NHS COVID-19 budget.

5.2 Specific responsibilities for Adult Social Care

- Identify an Executive Lead for the leadership and delivery of the Discharge to Assess model.
- Redeploy social work staff from the hospital setting to community settings to support discharged patients. Safeguarding investigations should continue to take place in a hospital setting if necessary.
- Ensure there are robust tracking mechanisms to track care placements so that care users do not get lost in the system at a time of very rapid response.
- Suspend need for funding panels for hospital discharge during the level 4 incident, with additional funding available to Local Authorities to cover any increased costs during this period.
- Provide social care capacity to work alongside local community health services to provide a single point of contact for hospital staff.

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- Support real time communication between the hospital and the single point of contact, not just by email.
- Provide capacity to review care provision and change if necessary, at an appropriate point.
- Work closely with community health providers over the provision of equipment.
- Ensure there is 7 day working for community social care teams (to be commissioned by local authorities).
- Deploy adult social care staff flexibly in order to avoid an immediate bottlenecks in arranging step down care and support in the community and at the same time focusing on maintaining and building capacity in local systems

6. What are the actions for Clinical Commissioning Groups?

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

- Coordinate local financial flows for NHS COVID-19 spend, including monitoring all local spend, coordinating local funding arrangements and work in partnership with local Government to support them in their lead contracting role in the local system.
- Comply with NHS England and NHS Improvement financial controls and reporting as set out in Section 10.
- CCGs should follow the guidance on NHS Continuing Healthcare in line with the detail found in Annex G.
- Free up staff resource from NHS Continuing Healthcare assessment processes to support the discharge-to-assess activities and transfer staff to local providers to support these new discharge arrangements.
- Arrange for community health end of life teams to take responsibility for any “fast track patients” end of life care patients needing support and step down.
- Co-ordinate and lead the rapid implementation of the Capacity Tracker (see Annex F) and NHS mail in care homes and hospices throughout their local area (see Section 8.3).

7. What are the actions for the Voluntary Sector?

Many systems already work with the voluntary sector to facilitate swift and safe discharges. In the current situation immediate consideration should be given to increasing the capacity of these services

7.1 The sector should:

- mobilise quickly and focuses on safety and positive experiences for patients on the discharge process, enabling patients to feel supported at home. They can also help reticent patients feel much more comfortable about being discharged
- Provide a range of practical support to facilitate rapid discharge, including transport home and equipment such as key safes
- Support discharged patients with home settling services to maintain wellbeing in the community (e.g. safety checks and essential food shopping)
- Provide ongoing community-based support to support emotional wellbeing, such as wellbeing daily phone calls and companionship
- Engage with NHS providers (particularly discharge teams) to provide solutions to operational discharge challenges, freeing-up clinical staff for other activities – focusing on the patients on pathway 0
- Utilise embedded local voluntary organisations in discharge pathways and enhance with input from large voluntary organisations
- Coordinate support between voluntary organisations and existing volunteers within NHS providers.
 - In advance of discharge be at the patient's home to accept equipment
 - St John Ambulance can also provide assisted discharge where conveyance by ambulance is required

7.2 Voluntary sector assisted discharge scheme extension

- Over the winter months of 2019/20, the British Red Cross Age UK and St John Ambulance have been providing discharge support to 42 hospitals between them. The charities provide practical and emotional support for both inpatients and those attending A&E, then assist frail and vulnerable people home from hospital. This service can remove practical barriers to discharge

by freeing up the time of NHS staff to focus on clinical tasks, providing transport or escort home to resettle, and undertaking follow up safe-and-well checks once home. This service will now be extended to support up to 100 hospitals

7.3 NHS volunteers to support hospital discharge

In addition to the support being offered by charities as part of the response to COVID-19, hospitals should consider how to deploy their NHS volunteers to volunteering roles that can most reduce pressure on services. Many hospitals utilise volunteers to assist people in getting ready to go home from hospital, ensuring they have everything they need and that everything is in place at their place of residence. They can greatly speed up the discharge process and also reduce the likelihood of readmission by ensuring that the person has the right support and resources in place at home. Volunteers can also provide advice and signposting to community support services and increase patient's confidence about leaving hospital and going home.

- 7.4 NHS England and Improvement is setting up a new scheme to identify additional volunteers able to support the NHS led by the Royal Voluntary Service using the GoodSAM app as the digital platform.

8. What are the actions for Care Providers?

8.1 Care Home providers:

- Maintain capacity and identify vacancies that can be used for hospital discharge purposes
- Adopt from Monday 23rd March 2020 and implement the Capacity Tracker during the COVID-19 outbreak to make vacancy information available to NHS and social care colleagues in real time
- Providers of Care Homes, in partnership with their local Primary care Networks and Community Health Provider, should consider how best to support residents, and where already in place, embed the Enhanced Health in Care Home Framework in line with timescales already outlined by NHSEI which have been communicated to primary care providers. This will ensure their residents are better supported (7 days a week) by the NHS.
- Implement NHSmail in their care home from Monday 23rd March, to ease communication between NHS and social care colleagues. From Monday 23rd March 2020, faster NHSmail roll-out will be available to all care providers, to support safe and secure transfer of information. NHSmail is accredited for sharing patient identifiable and sensitive information, meaning it meets a set of information security controls that offer an appropriate level of protection against loss or inappropriate access.

To improve communication between health and social care during the COVID-19 outbreak, NHSX is speeding-up the roll-out of NHSmail and temporarily waiving the completion of Data Security Protection Toolkit (DSPT) to allow for quicker on boarding. This is in-line with information governance guidance for COVID-19.

These are temporary measures to improve communication during COVID-19. NHSX is committed to enabling care providers to choose the right communication solutions for them. Providers will be asked to give their own assurance that they are secure and post-COVID-19, afterward NHSmail regional teams will take providers through the full DSPT process, supporting them to accredit their secure email system or NHSmail for sharing in future.

- Where 'Trusted assessor relationships and arrangements are not in place with Acute providers, rapidly work with the discharge team to implement these rules and processes

8.2 Domiciliary care providers:

- Identify extra capacity to adult social care contract leads, that can be used for hospital discharge purposes or follow on care from reablement services.

8.3 Patient Transport:

Patient Transport Services (PTS) are a critical resource in moving non-emergency patients from one care setting to a more appropriate setting on another site. Demand for PTS will increase through this period, and services will need to be more responsive.

- All PTS providers, across the NHS, independent and voluntary sector, will be expected to provide support to enable the transfer of patients as part of the discharge process and to support transfers and discharge as a priority in order to maintain flow and maximise patient safety.
- Additional guidance on how PTS will be enabled to deliver through this incident, including adjustments to KPI monitoring and reimbursement models will follow.
- Organisations should also consider alternative transport options. This could include:
 - Local Authority owned or contracted vehicles
 - Volunteer cars
 - Voluntary sector resources
 - Taxi services
 - Use of patient / relatives' own car.

8.4 Equipment and assistive technology

The single coordinator will need to ensure there is access to sufficient equipment to support discharge of people with reablement or rehabilitation needs at home.

As part of this, the local commissioner for NHS and Social Care Equipment must ensure:

- Local equipment services (across the NHS and local government) have a sufficiency of supply of the more common items of equipment used to support people with reablement or rehabilitation or longer-term care needs
- Access to such equipment can be quickly (same day where needed) and easily facilitated seven days a week (utilising mutual aid with neighbouring areas or redeployment of community based staff if required). This may include the

purchase of additional equipment and the recycling, cleaning and reuse of equipment

- Providers are prepared for rapid implication of increased volumes of rehabilitation equipment, including same day delivery requests
- The availability of equipment that can be used to reduce the need for two carers to provide care to individuals, releasing workforce capacity
- Providers have access to adequate stocks of Personal Protective Equipment (PPE).
- Simple approval process for more complex patients requiring hospital beds, pressure relieving equipment and hoists. This should be through discussion and verbal approval to order. Current senior clinician approval process and equipment prescription matrices will be stood down
- Regular review and tracking of issued equipment to reduce over prescription of equipment. The responsibility for review of equipment once a patient is discharged will sit with the receiving care organisation
- Photographs supplied by family/carers/community staff including District Nurses as an alternative to completing access and risk assessment visits for more complex patients. If a visit is required, this will need to be arranged within 4 hours of decision to discharge
- Discharge tracking information is used to ensure regular restocking of buffer/satellite stores to maintain supply
- There is a comprehensive range of assistive technology items that can support people to live safely and independently at home with next day access to support if required. This goes significantly beyond falls pendants.
- Stock includes gas, carbon monoxide, smoke alarms including devices that supports people who are blind and/or deaf, and temperature detectors. Movement detectors, bed/chair occupancy detectors and flood detectors.
- There are enuresis sensors, epilepsy sensors and medication dispensers covering a 28-day period.
- Equipment can be made available at low-cost and can be simple to fit without hardwiring..

9. Monitoring and increasing rehabilitation capacity

9.1 After the first phase of discharging existing patients who do not meet the criteria for being in an acute hospital, it will be essential to maintain this approach in any rehabilitation and step down facilitates and broader care-at-home services. This will avoid creating blockages in the community facilities/services and stop the next sets of patients being discharged from acute care.

9.2 Pathways 1, 2 and 3:

- Of those patients discharged to short-term reablement/rehabilitation pathways approximately 35% are likely to require long term care at home or placement in a 24-hour residential or nursing setting.
- It is essential that people on these pathways are tracked and assessed after a period of recovery. Longer-term care or placement must be made available at the right time to ensure that the pathways are not blocked for future patients needing discharge from hospital.

9.3 Community Hospitals

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

- A daily clinical review of the plan for every patient focusing on three questions
 - Why not home?
 - What needs to be different to make this possible at home?
 - Why not today?
- The review process should explore why people require rehabilitation in a bedded setting. It is accepted that the majority patients will be medically stable in this setting.
- All patients should have an expected date of discharge (EDD) and be fully involved with their discharge planning. Essential that expectations are set at the point of transfer or admission

- The review should specifically look at whether people can be supported at home. The default assumption will be discharge home today
- All actions from the review should be noted and aimed to be completed by the end of the day.

9.4 Short-term placement for people who require 24-hour supervision and care

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

9.5 Short term rehabilitation/reablement-at-home review

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

10. Finance support and funding flows

- 10.1 The Government has agreed to fully fund the cost of new or extended out-of-hospital health and social care support packages, referred to in this guidance, for people being discharged from hospital or would otherwise be admitted into it for a limited time, to enable quick and safe discharge and more generally reduce pressure on acute services. There will be separate announcements on local government resilience funding for social care.
- 10.2 This section sets out the financial support available for this care and support capacity and enhanced discharge support services from NHS England and Improvement; how finance support will flow to CCGs; and how the relevant commissioning budgets should be managed locally.
- 10.3 There will be a suspension of usual patient funding eligibility criteria while this process is in place. NHSE&I will ensure there is sufficient funding to support CCGs and their local authority partners to commission the enhanced discharge support outlined in this guidance. CCGs are expected to ensure that an appropriate market-rate is paid for this support. This includes liaising with their local authorities to agree an approach to ensuring the market can sustain a rapid and significant increase in supply. This appropriate market-rate may need to reflect that some patients and the capacity being utilised would previously have been self-funded.
- 10.4 This NHSE&I funding support will commence from 19th March and will reimburse, via CCGs, the costs of out-of-hospital care and support that arise as a result of the approach outlined in this document (both new packages and enhancements to existing packages), where it is provided to patients on or later than this date. Any patients already receiving out of hospital care and support that started before this date will be expected to be funded through usual pre-existing mechanisms and sources of funding.
- 10.5 This funding agreement will be kept under review. CCGs and local authority partners will be notified by NHSE&I or DHSC when this no longer applies to new patients.

Proposed finance route from CCGs for additional discharge support services

10.6 In order to expedite the most appropriate flow of funds and minimise administrative burden, the following process should be followed.

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

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

10.9 Where CCGs and local government agree, BCF section 75 agreements can be extended or varied for this purpose^[1]. A model template for a variation to a section 75 agreement is available on the NHS England website^[2].

10.10 The funding provided should be separately identified within the agreement and monitored to ensure funding flows correctly. It should be pooled alongside existing local authority planned expenditure on discharge support. Support provided and agreed budgets from this funding should be recorded at individual level. Where care is

^[1] The Better Care Fund Policy allocations for the [CCG minimum contribution](#) and the [improved Better Care Fund](#) have been made public.

Although BCF plans from April 2020 will not have been formally approved, for the duration of the current outbreak of COVID-19, systems should assume that spending from ringfenced BCF funds, particularly on existing schemes from 2019-20 and spending on activity to address demands in community health and social care, is approved and should prioritise continuity of care, maintaining social care services and system resilience.

^[2] <https://www.england.nhs.uk/ourwork/part-rel/transformation-fund/bcf-plan/risk-sharing/>

most appropriately commissioned directly by NHS commissioners, this should be placed under existing contractual arrangements with providers but invoiced separately to ensure that enhanced discharge support funding is identifiable. This care should be paid for from the additional funding set out in this section.

10.11 Where a patient has been admitted to secondary care and had previously been in receipt of a funded care package (either in a care-home or in their own home) this guidance and additional funding is intended to support the restart of such a package also. I.e. restarted care following discharge will be counted as covered by this additional funding.

10.12 CCGs and local authorities should work with the trusts from which patients are being discharged, and with their community services and voluntary sector partners, to ensure that the most appropriate enhanced discharge services are being provided and that these align with the needs of patients that the trusts are seeing.

10.13 Commissioners should work with providers of discharge services to ensure that extending existing contracts will be financially sustainable for those providers, and consider mitigating actions where there is a risk that they will not be.

Reimbursement routes and cashflow

10.14 CCGs should ensure that both they and any local authorities commissioning on their behalf reimburse their providers in a timely fashion, reflecting differing cash-flow requirements of those providers – paying particular consideration to smaller providers. Local authority and CCG commissioners should refer to guidance published by the Local Government Association, ADASS and the Care Provider Alliance on social care provider resilience during COVID-19.

10.15 NHSE&I expect ordinary financial controls to be maintained with respect to invoicing, raising of purchase orders and authorising payments. However, CCGs should ensure that there is not an undue administrative burden that slows down the commencement of the enhanced discharge support services. Where necessary, retrospective approvals and approaches to the degree of detailed financial scrutiny appropriate to achieving this aim should be undertaken.

10.16 NHSE&I will reimburse CCGs through the monthly allocation process. CCGs should, from the commencement date, maintain a record of the costs and activity associated with the enhanced discharge process so that they can submit a claim for additional payment for this from NHSE&I using a centralised approach that will be separately communicated.

10.17 Whichever model is followed CCGs should record the costs associated with this and link in with other wider COVID-19 financial reporting requirements. CCGs should expect to be asked for monthly updates on the costs of these services.

Enhanced discharge support – cessation process

10.18 Commissioners should plan throughout the period that the enhanced discharge support process is running to ensure appropriate processes are in place for the period following cessation of the enhanced discharge support process. As part of this, planning conversations should be taking place with patients and their families about the possibility that they will need to pay for their care later, as appropriate.

11. Reporting and performance management

- 11.1 Current performance standards on DTOC monthly reported delays will be suspended from 19 March 2020.
- 11.2 Trusts should continue to report DTOC figures through the usual process, but will not be performance managed on them during the period of the incident.
- 11.3 Providers of community rehabilitation beds must start reporting DTOC figures on a daily basis to NHS Digital from Monday 23rd March.
- 11.4 NHS providers will be required to report the following during the Incident:
- (1) Bed occupancy in hospitals – via daily sitrep
 - (2) Number of patients on daily discharge list
 - (3) Number and percentage of patients successfully discharged from discharge list
 - (4) Bed availability in community settings, via the Capacity Tracker Tool
- 11.5 Clinical Commissioning Groups will be required to submit the monthly financial spend to NHS England for reimbursement.

12. Additional resources and support

Webinars

- 12.1 To support implementation, NHS England will be running webinars to run through the guidance and provide local areas with the opportunity to ask questions. This will be supported by Frequently Asked Questions which will be regularly updated.
- 12.2 The webinars are for all those involved in discharge, at all levels and from all organisations -CCGs, local government, health and care providers, housing, voluntary and community sector and social care providers. The webinars will be the same content run over four different sessions during the weeks commencing 16 March and 23 March 2020.
- 12.3 To register for the webinars, the web link is:
<http://www.supportingdischarge.eventbrite.co.uk>
- 12.4 Over the next few days and weeks we will also be running virtual support clinic sessions to answer specific local queries. Further details on these clinics will be available on the webinars noted above.

Supporting guidance

- 12.5 This document should be read alongside the 2015 NICE guideline, Transition between inpatient hospital settings and community or care home settings for adults with social care needs.
<https://www.nice.org.uk/guidance/ng27/resources/transition-between-inpatient-hospital-settings-and-community-or-care-home-settings-for-adults-with-social-care-needs-1837336935877>
- 12.6 Discharge to Assess also forms part of the High Impact Change Model (HICM) for hospital discharge.
<https://local.gov.uk/our-support/our-improvement-offer/care-and-health-improvement/systems-resilience/refreshing-high>
- 12.7 For further detail on discharge to assess, please see the D2A Quick Guide
<https://www.nhs.uk/NHSEngland/keogh-review/Documents/quick-guides/Quick-Guide-discharge-to-access.pdf>

12.8 Shared guidance to local authority commissioners from the Association of Directors of Adult Social Services (ADASS), the Local Government Association (LGA) and the Care Provider Alliance (CPA)

<https://www.local.gov.uk/social-care-provider-resilience-during-covid-19-guidance-commissioners>

Annex A: The Discharge to Assess Model

This model, based on best practice, assumes that:

95% of people can go straight home on discharge:

- 50% can go home with minimal or no additional support (Pathway 0)
- 45% can go home with a short or longer-term support care package (Pathway 1)

5% of people will require residential or nursing care setting:

- 4% require rehabilitation support (Pathway 2)
- 1% require nursing home care (Pathway 3).

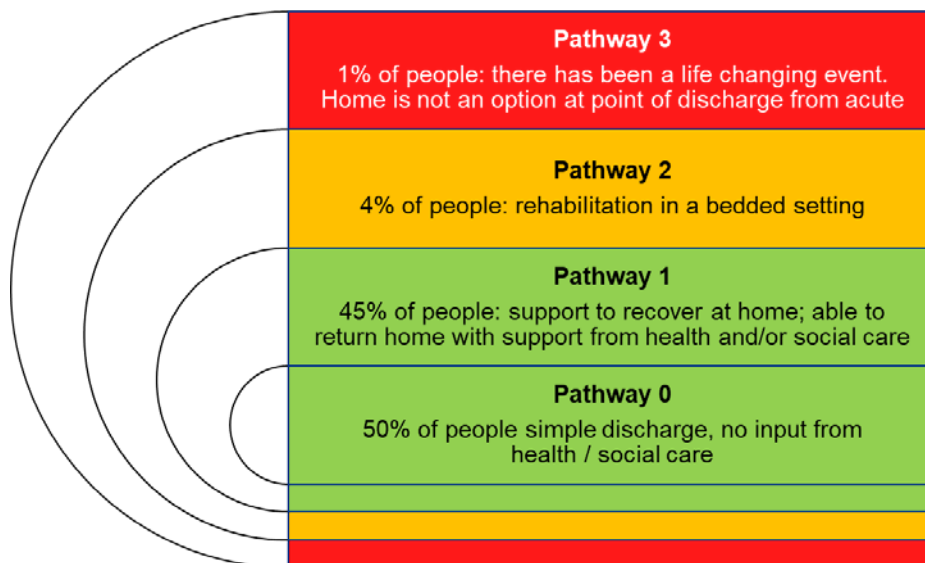


Figure 1: Discharge to Assess model

There are three stages to the discharge to assess model:

<p><u>Stage one</u></p> <p><u>Review patients daily and identify patients for discharge to leave that day</u></p>	<ul style="list-style-type: none"> ✓ Clinically-led review of all patients at an early morning board round, any patient meeting the revised clinical criteria will be deemed suitable for discharge ✓ At least twice daily review of all patients in acute beds to agree who is not required to be in hospital, and will therefore be discharged: ✓ All patients who are not required to be in hospital and are therefore suitable for discharge will be added to the discharge list and allocated to a discharge pathway.
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	<ul style="list-style-type: none"> ✓ Discharge home should be the default pathway ✓ The discharge list will be managed by the community provider with the lead responsibility for ensuring the Discharge Service Requirements are met – this provider will be the single coordinator
<p><u>Stage two</u></p> <p><u>The details of how to discharge patients</u></p>	<ul style="list-style-type: none"> ✓ On decision of discharge, the patient and their family or carer, and any formal supported housing workers should be informed and receive the relevant leaflet (see Annex K) ✓ Community health, social care and acute staff need to work in full synchronisation (and include housing professionals where necessary) to ensure patients are discharged on time. ✓ The delineation of responsibility to coordinate and manage the discharge arrangements are expected to be: <ul style="list-style-type: none"> ○ Pathway 0 – acute discharge staff lead ○ Pathways 1, 2 and 3 – community health staff lead ✓ On decision of discharge, all patients will be allocated a case manager by the single coordinator ✓ All patients must be transferred to an allocated discharge area/lounge within one hour of decision to discharge ✓ The case manager will be responsible for ensuring: <ul style="list-style-type: none"> ○ Individuals and their families are fully informed of the next steps ○ Patient transport home is available, where needed ○ ‘Settle in’ support is provided where needed ✓ Senior clinical staff should be available to support staff with positive risk-taking and clinical advice ✓ Where applicable to the patient, COVID-19 test results are included in documentation that accompanies the person on discharge
<p><u>Stage three</u></p> <p><u>Assessment and care planning at home</u></p>	<ul style="list-style-type: none"> ✓ Post discharge, the single coordinator will need to ensure the staff and infrastructure is available to provide immediate care needs, review and assess for longer-term care packages or end support where it is no longer needed.

	<ul style="list-style-type: none">✓ The single coordinator should draw on all available local resources, including the voluntary and community sector and social care staff no longer undertaking assessment work in the acute units.➤ Coordinated home assessments between health and social care, including equipment and reablement support, take place ideally on the same day of discharge, led by a trusted assessor
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Important considerations for all pathways:

- Duties under the Mental Capacity Act 2005 still apply during this period. If a person is suspected to lack the relevant mental capacity to make the decisions about their ongoing care and treatment, a capacity assessment should be carried out before decision about their discharge is made. Where the person is assessed to lack the relevant mental capacity and a decision needs to be made then there must be a best interest decision made for their ongoing care in line with the usual processes. If the proposed arrangements amount to a deprivation of liberty, Deprivation of Liberty Safeguards in care homes arrangements and orders from the Court of Protection for community arrangements still apply but should not delay discharge.
- For patients identified being in the last days or weeks of their life Hospital or Community Palliative Care teams will be responsible for co-ordinating and facilitating rapid discharge to home or Hospice. This supersedes the current fast track end of life process.

Annex B: Maintaining good decision making in acute settings

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

- Requiring ITU or HDU care
- Requiring oxygen therapy/ NIV
- Requiring intravenous fluids
- NEWS2 > 3
(clinical judgement required in patients with AF &/or chronic respiratory disease)
- Diminished level of consciousness where recovery realistic
- Acute functional impairment
in excess of home/community care provision
- Last hours of life
- Requiring intravenous medication > b.d. (including analgesia)
- Undergone lower limb surgery within 48hrs
- Undergone thorax-abdominal/pelvic surgery with 72 hrs
- Within 24hrs of an invasive procedure
(with attendant risk of acute life threatening deterioration)

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

Review/challenge questions for the clinical team:

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

Criteria- ed discharge:

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

Annex C: COVID-19 Trusted Assessor guidance

- 12.9 This guidance is an interim supplement to CQC's [Guidance on Trusted Assessor Agreements](#). It has been written to support NHS and social care providers and Trusted Assessor schemes during the COVID-19 pandemic. It will apply until further notice.
- 12.10 This update seeks to further remove and reduce delays in decision-making processes that can stop patients who are ready to be discharged from leaving NHS acute or community beds. Shifting to this revised approach will require hospital staff, providers and other partners to work in new and different ways.
- 12.11 The Government is bringing forth legislation to allow CCGs to delay assessments for CHC until after the conclusion of the coming period, including for individuals being discharged from hospital. This means the priority can be on timely discharges, with eligibility assessments and funding decisions taking place afterwards.
- 12.12 'Trusted Assessor' schemes are a national initiative designed to reduce delays when people are ready for discharge from hospital. Providers adopt assessments carried out by suitably qualified 'Trusted Assessors' working under formal, written agreements.
- 12.13 Assessments and care planning can be undertaken by Trusted Assessor schemes in a way that meets both people's needs and legal requirements on providers.
- 12.14 Providers accepting trusted assessments must have access to a process by which they can escalate concerns when a person has been discharged to their service with needs they are unable to meet. The process must be able to respond to those concerns promptly. Where a concern is raised about the appropriateness of the placement, CQC will expect this to be considered promptly.
- 12.15 Key changes from existing arrangements:
- (1) All hospitals will train additional discharge staff to operate as 'Trusted assessors'. Trusted Assessors will continue to support care providers with discharge arrangements. The additional staff will supplement Trusted Assessors in existing schemes.
 - (2) Most hospitals already use trusted assessor schemes for discharges to care homes and care at home services in their areas. These should be kept up to date in local NHS Discharge to Assess (D2A) arrangements. This should be prioritised.
 - (3) Over this period CQC's priority is to continue to check that people are safe. Where we have serious concerns, we will use inspection and other processes to do so.

- (4) Registered providers and managers will need to have confidence that legal requirements for assessments will be met, and that particular consideration will be given to safety and infection control-related needs during this heightened period.

Annex D: Patient discharge choice leaflet

It is recognised that issues of patient choice and engagement can often be significant barriers to hospital discharge where there are ongoing social care needs after discharge (particularly if moving to a residential or nursing home). During the COVID-19 response there will be suspension of choice protocols for this particular issue. The following leaflets have been produced to support the communication of this message.

Leaflet A – to be shared and explained to all patients on admission to hospital

Leaflet B – to be shared and explained to all patients prior to discharge, this is split into leaflets:

- Leaflet B1 for patients who are being discharged to their usual place of residence
- Leaflet B2 for patients moving on to further non-acute bedded care

Annex E: Homelessness

- The requirements of the homeless and people living on the streets, also need to be reflected in any local framework to support the Government's COVID-19 emergency.
- Practices that have been developed in systems to support homeless persons need to be maintained and enhanced to reflect the need to support the needs of those who are without a home and living on the street. It is already known that this group has a high level of mortality, and support needs including mental ill-health and substance misuse which may present a barrier to self-isolation.
- NHS trusts have a statutory duty under the Homelessness Reduction Act (2017) to refer people who are homeless or at risk of homelessness to a local housing authority. This statutory duty remains.
- To prevent homelessness from delaying discharge, the following should be followed:
 - Referrals should be made at the earliest opportunity as soon as it has been identified that a person may be homeless on discharge as this provides more time for the housing authority and other support services to respond. The person must give consent and can choose which authority to be referred to.
 - People who are homeless also need to be able to safely self-isolate to also prevent the need for greater care and reduce transmission risks.
 - Systems should be vigilant in spotting symptoms – using organisations and staff to spot potential COVID-19 positive persons who are homeless and have access to rapid triage to cohort people accordingly.
 - Local systems need to plan and provide for multiple venues to cohort and care for homeless people who are COVID-19 positive, thereby still managing people in the community where there needs to be spaces to keep people separate with provision on the street; accommodation, water, food, sanitation.

Annex F: Community rehabilitation & hospice bed capacity – Capacity Tracker

As part of current discharge planning there is an imperative to understand bed occupancy and vacancies in the community. The Capacity Tracker produced and operated by NHS North of England Commissioning Support (NECS) is to be used by all systems nationally to record their care home, community and hospice bed capacity.

The Capacity Tracker is an established web-based tool providing the opportunity to easily track bed capacity and vacancies to support system wide bed and discharge planning. It has been successfully operating to support care home bed planning for some time.

To support current discharge planning Capacity Tracker will maintain support to organisations already registered, but will be expanded to capture bed capacity data in all care homes, all hospices (including children's hospices) and from all providers of inpatient community rehabilitation and end of life care.

This is not intended to replace current information systems already being used in some localities to track bed / room vacancies, but to run in parallel

All the above providers are required to use Capacity Tracker to report the following vacancies and broader status information (in care homes only at this stage) to ensure consistency of approach and availability of a real-time single source of truth across England.

Data being collected will be:

- i. Number of beds
- ii. Number of bed vacancies
- iii. Current status i.e. Open / Closed to Admissions (care homes only), including number of COVID-19 residents
- iv. Workforce / staffing levels (care homes only)

This essential information will be included in daily national SitRep reporting to support capacity planning and response. It should also be used by localities to understand their bed base and support system wide discharge planning. To support reliable real time discharge planning when using Capacity Tracker it must be updated as close to real time as practicable – e.g. as and when any occupancy changes or at least once per day if there has been no change.

Accurate and timely data is essential for effective management of the response to the COVID pandemic bot locally and nationally

System activities/requirements

There needs to be rapid system wide adoption of the Capacity Tracker. It will go live on 23rd March, with comprehensive support for registration and operation being developed. The full support offer to enable organisations will include a call centre, online tools, and webinars to enable users to understand what they need to input and how.

All care homes, all hospices (including children's hospices) and all providers of inpatient community rehabilitation and end of life care are required to be fully using Capacity Tracker by 1st April 2020.

For current support please visit Capacity Tracker website address at:

<https://carehomes.necsu.nhs.uk/>. This weblink will signpost to wider resources when they are available to be released.

Prior to Capacity Tracker going live and to make this happen in the required timescale, CCGs must take the responsibility to each nominate a group of System Champions (more than one person is required to cover in the case of absence) who will oversee the rapid implementation of Capacity Tracker in their locality. Their name(s) and email address must be notified to NHS NECS via necsu.capacitytracker@nhs.net as soon as practicable.

Annex G: NHS Continuing Healthcare and COVID-19 Planning

NHS Continuing Healthcare as referred to throughout this document relates to individuals aged 18 or over.

NHS Continuing Healthcare COVID-19 emergency preparedness

Temporary Arrangements

Temporary arrangements for NHS Continuing Healthcare (NHS CHC) need to be implemented for the duration of the COVID-19 emergency period. These arrangements cover:

- The assessment of eligibility for NHS CHC funding;
- Individual requests for a review of an eligibility decision (i.e. Local Resolution and Independent Review); and,
- Three- and twelve-month reviews of NHS CHC packages of care

Objectives

The objectives of implementing any temporary arrangements for NHS CHC are:

- to expedite safe discharge of patients from acute hospital beds under EPPR arrangements.
- to reduce the NHS CHC assessment burden in and out of hospital settings; and
- to release clinical and support staff to support the system to manage the COVID-19 outbreak.

Emergency Measures to be implemented for NHS CHC during the COVID-19 Emergency Period

- The current legislation does not describe a specific timeframe for carrying out NHS CHC assessments of eligibility, or for individual requests for a review of an eligibility decision (i.e. Local Resolution and Independent Review). Therefore, NHS CHC assessments for individuals on the acute hospital discharge pathway and in community settings will not be required until the end of the COVID-19 emergency period. Planned legislative change, as part of the COVID-19 Bill, will further support the NHS in relation to this.
- Individuals can still make requests for a review of an eligibility decision (i.e. Local Resolution and Independent Review) however the time frame for a response will be relaxed.

- There is an expectation that CCGs will take a proportionate view to undertaking three- and twelve-month reviews to ensure that the individual's care package is meeting their needs and to ensure that any concerns raised are addressed as appropriate.
- Commissioning end of life services remains important therefore, and the Fast Track pathway tool can still be used for clinical assessments or other local tools as appropriate. However, to remove decision making delays, the responsibility to co-ordinate the arrangements for care at home or a hospice bed should be passed to local Community palliative care teams during this period.
- During the COVID-19 emergency period, CCGs will not be held to account on the NHS CHC Assurance Standards nor timeframes for dealing with NHS CHC individual requests for reviews of eligibility decisions.
- These measures set out for NHS CHC are only in place for the duration of the COVID-19 emergency period.
- Local systems need to ensure that they have some method of monitoring actions taken during the COVID-19 emergency measures, for example using the NHS CHC Checklist, so that individuals are assessed correctly once business as usual resumes.

Implications for Adopting the COVID-19 Emergency Measures for NHS Continuing Healthcare

- If NHS CHC full assessments of eligibility are deferred, a backlog of circa 5,000 assessments per month will be created which will have future workload implications for CCGs, NHS and Local Authority staff. The same will apply to individual requests for a review of an eligibility decisions (i.e. Local Resolution and Independent Review). A handling plan will need to be developed to enable the system to 'normalise' following the COVID-19 emergency period;
- There may be a financial impact upon CCGs funding under discharge to assess arrangements as part of the hospital discharge pathway for longer periods than usual and the COVID-19 emergency money can be used for this purpose.
- Where social care has been provided free at the point of delivery for the emergency period, the expectations of individuals in receipt of funded care packages that may not continue to be funded after the COVID-19 emergency period, this will need to be managed, as some individuals will need to return to usual funding arrangements, which will mean they may have to contribute or fully fund their care.
- Although NHS CHC is effectively a "funding stream", the clinicians involved in NHS CHC assessment and review are required to assess the specific needs of highly vulnerable individuals and to commission the relevant care. Therefore, it is still important to ensure that care packages are commissioned that meet the needs of these individuals.

Annex H: Overview of decision making and escalation

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



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

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



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

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