COVID 19 Hospital Service Discharge Requirements – Frequently asked Questions - Overview

What is this guidance about?

- The guidance describes measures that all systems must take to rapidly reduce occupancy in acute and community hospitals to ensure that people made acutely ill by COVID-19 can be cared for. Specifically
    - From 19 March, all systems must use a modified discharge to assess (D2A) model to discharge all patients who have been confirmed by a consultant as no longer meeting the criteria for acute care.
    - Once a decision has been made that someone should be discharged, they should be transferred to a discharge lounge or suitable designated area within one hour and discharged from hospital within a further two hours.

No further assessment in the hospital is required

- The guidance sets out arrangements for funding additional costs to health and social care that government is putting in place.
- Acute Trusts, Community Trusts and Local Authorities must agree a single discharge co-ordinator.
- The process is enabled by the temporary suspension of relevant elements of the Care Act (Section 2 and Section 5 notifications) and the timescales normally attached to these processes.
- The guidance also sets out requirements for all care homes and community hospitals to register on the Care Tracker tool (https://carehomes.necsu.nhs.uk/) and to use nhsmail.

What are you asking Trusts to do?

Acute providers are expected to update their processes and ways of working to deliver the discharge to assess model. As part of this they must:

- Identify all patients clinically fit for discharge, through an effective daily board round and refer them to the single local coordinator for the relevant discharge to assess pathways.
- Ensure tripartite professional and clinical leadership between nursing, medicine and allied health professions for managing the change process as well as delivering the outcomes.
- Implement new working arrangements for appropriate acute based staff, such as Occupational Therapists.
- Create safe and comfortable discharge spaces for patients to be transferred to within one hour of decision to discharge.
- Review and redistribute workforce to support discharge, assessment and support at home, (working with local NHS and Local Authority partners) including:
    - Increasing discharge assessment capacity to drive pathway 1, ensuring that people are assessed for short term care needs as they arrive home.
    - 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.

- 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 to ensure patients are supported (where needed) actively for the first 48 hours after discharge.
- 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 discharge arrangements.
- Use the High Impact Change Model https://www.local.gov.uk/our-support/our-improvement-offer/care-and-health-improvement/systems-resilience/refreshing-high. – Change 9 to ensure planning and discharge for people with no home to go to and that no-one is discharged to the street. See Annex I for further details on homelessness arrangements.

What are you asking community trusts to do?

- Community trusts need to
  - Appoint a single co-ordinator (new role)
  - 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.
  - Co-ordinate care for patients discharged via D2A pathways 1-3.
  - 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
  - Using multi-disciplinary teams to assess and arrange packages of support for patients on the day they are home from hospital on pathways 2 and 3.
  - Co-ordinate and facilitate rapid discharge to home or hospice for patients who are at the end of their life

What are you asking CCGs to do?

- Support the co-ordination of activities set out in the guidance by:
  - Co-ordinating local financial flows for NHS COVID spend,
  - Co-ordinating local funding arrangements
  - Agree with Local Government who should be the lead organisation for commissioning local nursing, domiciliary and other associated care services
  - Agree who should be the Lead Commissioner
  - Free up 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 "Fastrack patients" / end of life care patients needing support and step down.
  - Co-ordinate and lead the rapid implementation of the Capacity Tracker and NHS mail in care homes and hospices

What are you asking local government to do?

- All local authorities with social care responsibility should work in partnership with CCGs and Trusts to implement and deliver discharge to assess and provide joined up care for people being discharged from hospital. This will include:

- Agree with CCGs who should be the lead organisation for commissioning local nursing, domiciliary and other associated care services
- Agree who should be the Lead Commissioner
    - Appointing an executive lead for delivery of the D2A model
    - A lead point of contact for each acute trust
    - Work with health colleagues to pool staffing and make the best use of resources to support people being discharged, including redeployment of staff from hospital to carry out assessment and provide support at home
    - Suspend funding panels. Costs of additional care are being centrally funded via the NHS for this time.
    - Co-ordinate work in your area with voluntary sector organisations, liaising with trusts.
    - Ensure that there is seven day a week working for community social care.

Will there be an agreed date to implement so we all implement the guidance at the same time?

- The new measures must be implemented from 19 March 2020.

What will 'normal working hours' look like for discharge under these new arrangements?

- 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.

My community trust doesn't have the capacity/locus to co-ordinate these pathways. What do we do?

- We are expecting systems to have close co-ordination across the entirety of this process. Community trusts have been identified as being best placed to lead on these pathways as they will be closely involved in the therapeutic input for these. The guidance states that:

  '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'.
- Where community health providers do not have the capacity to co-ordinate assessment and support on these pathways, a different arrangement can be put in place if this is the only way to ensure effective delivery of the new requirements. Local system leaders must agree this change through local escalation routes, and with the Local Resilience forum and Gold Command.
- A single point of co-ordination must be in place though, who should be a person within the system with the right skills and experience to operate this process, senior enough to make the necessary decisions. All partners must work with them to deliver the new process.

In our system the LA leads pathway 1&3 and it would cause difficulties to transfer responsibility to a community provider. Is this flexible?

- See above, processes can be agreed locally, but must go via the appropriate local escalation routes

What is the government paying for?

- Government will fully fund the costs of additional out-of-hospital care and support that arise as a result of the approach outlined in the guidance (both new packages and enhancements to existing packages), where it is provided to patients after 19 March 2020.
- The funding will also cover the costs of additional short term residential intermediate care capacity to reduce hospital admissions (step up).
- Local authorities should pool existing funding for discharge support with this additional money. Once pooled, funding should be treated as a single pooled fund and used to deliver the appropriate care for individuals to be discharged under these new arrangements. The funding should be identifiable separately and support and spending from this new pooled funding should be recorded for each individual discharged and supported under these arrangements.

How long will these arrangements continue for?

- 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.

What happens when the support ceases?

- Further details on the cessation process will be issued over the coming months, however, 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.
- Funding will continue for these patients for a short period during the post-cessation phase, and NHSE&I will work with CCGs and Local Authorities to ensure that an appropriate amount of time is allowed.

What services/activities are excluded?

- Requirements under the Mental Capacity Act 2005 continue to apply and, if you suspect that a person lacks the relevant capacity to make decisions about their ongoing care, a capacity assessment should be made, and a best interests decision made in the usual way.
- Procedures relating to Deprivation of Liberty Safeguards remain in place.
- These requirements and the funding that was announced to support it do not apply to children.

What are the arrangements for patients in Mental Health Trusts? Do section 117 assessments need to be carried out?

- These requirements only apply to Acute and community providers. They do not apply to mental health trusts and section 117 assessments should be carried out.