

To implement the discharge to assess model, community service providers set up rapid coordination hubs to plan and enable discharge from acute hospitals. These efforts were often supported by rapid response services that managed incoming NHS 111 calls for people with COVID-19 symptoms and helped prevent avoidable admissions. The short case studies below show how community services implemented the hospital discharge requirements, redeployed staff such as community nurses, and managed to successfully reduce bed occupancy.

Surrey Downs Integrated Care Service is comprised of six partners including the county council, GP federations, community care provider and acute trust. It has a multidisciplinary team that supports discharge to assess, rapid community response, A&E front door and community hospital beds. The @home service launched in 2016 supports patients over 65 at home as an alternative to hospital admission and has seen a 6 per cent reduction in admissions over the past three years. Key principles were developed around bed usage, which helped shape pathways including home first, avoiding multiple moves where possible and maximising local capacity. The integrated discharge services, including the @home service, reduced community hospital capacity by 50 per cent in preparation for the surge of COVID-19 cases.

Great Western Hospitals NHS FT worked with local partners, including social care and charities, to bolster care in the community during their COVID-19 response. They created a robust seven day 8am to 8pm service to support patients affected by COVID-19 directly or indirectly. This service reduced acute bed occupancy to 50 per cent at the height of the pandemic's first peak, as well as a sustained reduction in the number of medically fit patients waiting for discharge and over 21-day stranded patients. Most patients have gone home with wraparound support. This was possible as staff and volunteers took on duties beyond their normal scope. For example, podiatrists supporting tissue viability nursing services and therapists undertaking care visits.

Anglian Community Enterprise (ACE) community interest company reorganised its discharge model within days to support the timely discharge of patients from hospital. This involved redeploying staff from community therapy services to manage the discharge to assess process from both acute and community hospitals, with support from social care colleagues on more complex cases. The discharge team has oversight and case management input for all discharges on pathways 1–3, which are all tracked from the initial local setting to the final destination by the ACE discharge tracker. This tracker enabled ACE to develop a sitrep showing a system-wide view of discharge capacity in health and social care settings.

The sitrep provides a real-time tracker for activity and quality metrics and is used to make evidence-based decisions about discharges. This has delivered improvements to the use of home first. ACE is now working with the CCG to use this data for improved population health management and the ICS is looking to roll the sitrep out to other parts of the system. The discharge team enables ACE to be more responsive with earlier input into appropriate care needs, provide more support to hospitals in the discharge process, which should improve the safety of discharges, and support admission avoidance.

This multidisciplinary approach and integrated working is increasing knowledge around issues such as safeguarding and helping to build good relationships. To sustain this innovation, ACE supports a joint commissioned service with associated timescales, funding and key performance indicators. This will help provide clarity around a staffing model, as redeployed staff will soon need to be released back to their substantive roles.