STAFF FACTSHEET

NHS
Imperial College Healthcare
NHS Trust

# Safe and prompt hospital discharge

**Discharge planning should start when a patient is admitted to our care and be approached with a 'home first' mindset. On admission, every patient should be told their expected date of discharge and kept up-to-date with any changes to help them prepare for leaving hospital.**

## 1 Trust discharge services and support

Most discharges are simple and should be managed by ward managers and the multidisciplinary teams, working directly with social workers and community teams.

There are a number of support services within the Trust to help ensure your patients can be discharged as safely and promptly as possible.

### a. Complex discharge team

For more complicated cases – for example, for patients with high care needs who may need a place in a care home, where there are funding issues, or for patients who have behavioural challenges, the complex discharge team will provide support.

### How do I refer a patient to the complex discharge team?

The complex discharge is available across our hospitals providing medical care, Monday to Friday, 09.00 – 17.00, by calling the relevant site extension number.

- Charing Cross Hospital, call ext: **17461**
- Hammersmith Hospital, call ext: **34721**
- St Mary's Hospital, call ext: **21360**

### b. Discharge unit

If you have a patient, at Charing Cross or St Mary's hospitals, who is ready to go home and waiting for transport or someone to collect them, transfer them to the discharge unit, where they can wait comfortably.

### How do I refer to the discharge unit?

The discharge unit is open Monday to Friday, 09.00 – 17.00, you can bleep or call the relevant site extension number.

- Charing Cross unit – lead coordinator, bleep: **1630** or ext: **15120**
- St Mary's unit – lead coordinator, bleep: **2128** or ext: **21719**

### c. Patient choice policy

When a preferred care home or nursing home is not available interim care may need to be considered. To support you with these conversations letter templates and guidelines are available on the intranet to help give patients and relatives clear timelines and avoid delays in discharge.

### d. Long stay patients

Escalate all patients identified with a red day delay to your nurse in charge, ward manager or to the site team out of hours. Identify patients with long length of stay and escalate to site-based long stay meetings for MDT review, focusing on what needs to happen for them to be discharged. For patients with stays over 21 days, log an emergency care improvement support team (ECIST) code to record the reason for delay. This information is used at the weekly 'diamond call' with external partners to escalate issues so barriers can be resolved to get the patient home.

### c. Interim and rehabilitation beds

The bedded interim and rehabilitation teams work alongside the complex discharge team to help older patients who no longer need to be in hospital but do need on-going rehabilitation, or longer term care (care packages at home or care home placement). The teams consist of therapists and a nurse who will assess patients on the wards, decide on the most appropriate community unit and arrange for a bed.

These interim and rehabilitation beds are at Garside House Nursing Home, Farm Lane Care Home, Alexandra Rehabilitation Unit and Athlone House Rehabilitation Unit. The service is for patients aged 65 years or over living in Hammersmith & Fulham, Kensington & Chelsea, and Westminster.

Assessments for referred patients are carried out within 48 hours by a therapist or Care UK nurse assessor and, if appropriate, admission should take place within 24 hours.

### How do I refer a patient to the interim and rehabilitation beds?

Referrals for an interim bed at Garside House Nursing Home and Farm Lane Care Home can be made by contacting the complex discharge team. Referrals to Athlone and Alexandra rehabilitation units can be made using the Central London Community Healthcare (CLCH) NHS Trust community bedded services referral form and email to: **clcht.spa.referral@nhs.net** or call: **030 0033 3251**

## 2 Community-based services

Medically fit patients who need a little more support at home can be discharged and assessed at home – rather than staying in hospital waiting for an assessment. Depending on where your patient lives, there are community services available to provide rapid assessments and on-going care at home. The services are slightly different in each area and so you need to contact the service relevant to your patient.

### Community Independence Service (CIS)

The Community Independence Service (CIS) is provided in Hammersmith & Fulham, Kensington & Chelsea, and Westminster. The teams provide rapid response for prevention of non-elective admission, as well as community rehabilitation in partnership with Adult Social Care Reablement. CIS also has Homefirst teams who link with our hospitals and can start services at home on the same day. Patients can be discharged and assessed at home within two hours of discharge, if they are medically fit and are safe to be at home while they wait.

Services are provided seven days a week, between 08.00 – 20.00. Homefirst referrals – patients should be home by 14.00. Rapid Response referrals for community patients should be made by phone before 18.00.

### STARRS

The short-term assessment, rehabilitation and reablement service (STARRS) is an intermediate care service for patients living in Brent. The team offers a range of health care, rehabilitation and reablement services for patients who live in Brent, including a rapid response service, early supported discharge, and short-term rehabilitation providing neurological and general rehabilitation at home.

Services are available seven days a week, 08.00 – 20.30.

### How do I refer a patient to community-based services?

To refer to the community independence service, call:

- St Mary's Hospital Homefirst liaison team, call: **078 0889 0994**
- Charing Cross Hospital Homefirst liaison team, call ext: **11884 / 11881** or mobile: **078 3439 0362**

To refer to STARRS, call: **020 8453 2233**

### Community Service in other boroughs

There are a number of other community-based services in north west London who provide similar services.

| Borough/ CCG | Ealing | Harrow | Hillingdon | Hounslow |
|---|---|---|---|---|
| **Pathway** | Rapid Response | Rapid Response | Hillingdon Rapid Response | Single Point of Access |
| **Service provider** | Ealing Community Partners Referral Hub | Central London Community Healthcare | Central & North West London | Hounslow & Richmond Community Healthcare |
| **Hours of operation** | 24 hours a day, 7 days a week | Mon – Sun 08.00 – 20.30 | Mon – Sun 09.00 – 00.30 | Mon – Sun 07.00 – 19.00 |
| **Last referral** | 18.00 (for same day) | 18.00 | 17.00 | 19.00 |
| **Contact number** | 030 0123 4544 | 030 0555 8889 (option 2) | 018 9563 3546 | 020 8973 3450 |

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