

Change 8: Improved discharge to care homes

	Not yet established	Plans in place	Established	Mature	Exemplary
Discharge support	Best practice in discharge planning is not established and there is little trust between care homes and hospitals.	Systems are reaching out to care homes to find out where the systems need to change.	Systems have a regular dialogue with care homes (ideally through the care forum) and discharge is a regular agenda item.	Care homes and systems work in tandem to facilitate discharges seven days a week including evenings.	Care homes report few poor discharges or failed discharges as a result of system failure.
Enhanced primary care	Care homes are not linked with local community and primary care.	Scoping is underway to understand care home need. Plans have been made to establish clear links with primary and community care.	Community and primary care support provided to care homes on request. All care homes have access to a consistent, named GP.	People with increased acuity are well-managed in care homes due to a strong support network with primary and community care.	Care homes are supported by their named clinical lead and have access to primary care support. They are able to access support and advice on managing COVID and supported to make the right decision for their provision.
Access to out-of-hours/urgent care	High numbers of referrals to A&E from care homes, especially in the evenings and at weekends.	Specific high-referring care homes identified, and plans developed to provide better support.	Dedicated intensive support provided to high-referring care homes.	Improvement seen in unnecessary admissions from care homes, particularly on evenings and at weekends.	Across the system, care homes are well supported by access to out-of-hours/urgent care with appropriate COVID support where needed.