The diagram, used across both Bristol’s acute hospitals by ward staff, illustrates on one page how supported discharge from secondary care back into community care works in practice. There are now a set of consistent steps for organising and arranging a supported discharge:

1. Ward staff complete a single referral form (SRF)
2. A joint multidisciplinary team meet each morning at 11am to decide the best supported discharge route for each patient with a completed SRF
3. Intermediate care is the default option so that patients can be further assessed in their own home or a community bed
4. The joint support team at the hospital work to arrange the discharge within 48 hours

