Report of the Discharge Planning Sub-Group

The discharge planning work stream heard of many instances of accepted good practice and of initiatives that worked locally. However, it also identified areas for improvement. Discharge activity is not routinely spread across seven days and batching of decisions can occur on certain days, particularly following extended holiday weekends or at times of severe pressure on beds. The lack of weekend activity is across the whole system; decisions on readiness for discharge do not appear to be made and non-routine discharges are not being made over the weekend.

It has been said that a weighty document is not what is needed. It has further been suggested we avoid “buzz words” and just list the component parts that constitute good discharge arrangements. We have tried to take those suggestions on board. However, it has also been suggested that everyone involved knows what it is they are to do. Sadly, despite the remarkable performance in reducing delayed discharges last spring and, given the serious difficulties faced by the social care sector in the last year, the even more outstanding achievement in sustaining delays at lower levels, the evidence suggests that not everyone does know what to do. Or, if they do, they are not always doing it. The data, which shows lengthy hospital stays before and after readiness for discharge, a lack of activity at weekends, batching of referrals and referrals happening on or after the ready for discharge date, supports this. The conversations held with every health and social care partnerships also highlighted issues, noting there were also many examples of excellent joined up working.

The work stream agreed that a range of tools should be made available to support health and social care partnerships, also that whatever we propose needs to be measurable and accountable. Key actions could be developed in to a plan for local areas to decide how they will implement this locally. Agreed principles could be subject to scrutiny by Healthcare Improvement Scotland.

The resources to support good discharge planning should be set alongside work that is about to commence on delays associated with adults with incapacity, the work stream on community hospitals and intermediate care, and the Community Living Change Fund, aimed at tackling the entrenched complex delays involving people with severe learning disabilities and enduring mental health issues. It should also be placed in context of the wider work to redesign urgent care.

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On behalf of the Discharge Planning Sub Group

REPORT FROM THE DISCHARGE PLANNING SUB-GROUP

Contents

Introduction

Good discharge planning is an essential element of acute hospital patient flow and community service capacity, with the mismatch of demand and capacity an almost constant pressure for the NHS. Access is dependent on effective discharge processes to create sufficient flow. The planning of discharges, along with the importance of keeping to the plan, is therefore vital for bed management and patient flow. However, it is also important to allow strategic commissioners to plan for the requisite care in the community. This document attempts to bring together the key parts of good discharge planning.

There is good reason that the words “planning” and “plan” are used repeatedly in the opening paragraph. The words that will feature repeatedly in the rest of the document are “planned” and “early”. Early referrals, early involvement of the multidisciplinary team, including social care expertise, planning from an early stage in the patient’s journey through hospital. This involvement can seldom be too early and needs to be invited by timely and appropriate communication.

Guidance has long advocated the early setting of an Estimated Date of Discharge (EDD), also sometimes referred to as an expected or anticipated date. This has not always been consistently used and is even less often followed. It is also rarely subject to multi-disciplinary agreement, often arbitrarily set by ward staff. In terms of ensuring discharge arrangements are in place, evidence suggests it is not done in a planned way.

That is why we now want to change from EDD to PDD – Planned Date of Discharge. This is not just a change of word, although that in itself is important to drive behaviour from an “estimation” to a “plan” for each patient, but rather a cultural shift towards everyone involved in hospital discharge, including the patient, family and carers, to all work towards a jointly agreed date rather than, at present, working individually from the ready for discharge date.

We mention patients, family and carers, not just because there is a duty to involve them, but simply because they too need to be able to make their own plans for discharge and it is in everyone’s interests to ensure these are aligned. Older people and their carers should be involved from the outset so that their strengths can be properly identified, their goals discussed and expectations properly managed.
This equally cannot just be about setting the PDD to be as early as possible. It has to be realistic and that realism should then extend to conversations with families and carers about what support is wanted, is needed and can be offered. Premature discharge can be as poor an outcome as a delayed discharge and often leads to readmission.

There is much talk of the “whole system”. Delayed discharge is a whole system problem that needs a whole system solution. Delays come about when that whole system

working becomes fractured. Quite simply, in a system such as health and social care, the whole has to be more than the sum of its parts. It cannot operate by dividing the system in to parts and optimising the different parts. That is only likely to spin the wheels of one part of the system faster than the others when they need to operate in clockwork fashion with each other. The "journey" for the individual patient needs to be a seamless transition and not a series of handoffs. We discuss the different roles and responsibilities later in the paper and how they interplay with each other.

Good discharge planning should result in fewer delayed discharges, shorter lengths of stay and reduced hospital readmissions. Early actions and the use of PDD should enable an assertive approach to managing risk. Equally, reducing lengths of stay will require being seen by the right person in the right ward, early involvement of the multi-disciplinary team, consistency in the use of PDD and clear clinical criteria for discharge. PDD will only work effectively if there is sufficient capacity to support people to return home or to another setting. Data will be important in monitoring the effectiveness of PDD but also to enable the strategic planning of services to support discharge, particularly in commissioning the support of the third sector.

Poor discharge planning for older people can lead to adverse outcomes, lengthy delay in discharge and readmission.

When talking about good discharge planning supporting the management of hospital pressures, it is ironic that many cultural and behavioural improvements were seen in the early stages of the pandemic, when attendances and admissions were vastly reduced and when, for a short period, there was little pressure on hospital beds.
This paper identifies the key themes of good discharge planning, taking account of the lessons learned exercise that was carried out in July 2020, which looked at the changes made in March-June 2020 that saw delayed discharges reduce by over 60%. We need to build on the collaborative working that was in evidence at that time, when there was a strong common sense of purpose, with shared goals and joint commitment.

Summary of Discussion

The group initially developed discussion along key themes – Home First, single point of access, rapid response, intermediate care/community hospitals, staff profile/staff mix, whole system approach, outcomes and data, communication, and enablers and agreed key actions against them. These actions are listed in the report and are separated in to actions that each partnership "must do", "should do" or "could do".

The "must do" actions are those that the group felt needed to be in place across Scotland for consistency. These include the adoption of Planned Date of Discharge and the need for early referrals. Bed based intermediate care works in most areas but it is accepted that there are good reasons why some partnerships decided against it, so actions such as that are listed as "should do". In addition, there are a few actions that partnerships "could do", where they might want to check further information of what works well elsewhere. For example, some partnerships operate successful discharge hubs which can be located in an acute hospital or the community. There are is also

contrasting evidence about whether it is better to have dedicated social work teams based in an acute hospital or have community teams in reaching.

Home First

The principles behind a successful Home First approach are now fairly well established. These are largely inter-changeable with "discharge to assess" or just good discharge planning, but also bring in admission avoidance, accessing the right acute specialty where admission is required and quick turnaround for those admitted. All essentially things that are aimed at keeping people at home, living as independently as possible, for as long as possible. Unnecessary or prolonged hospitalisation, can lead to deconditioning and long-term loss of independence, often resulting in premature and avoidable placement in residential care.

That is not to suggest hospitalisation should be avoided at all costs. There is strong evidence that a comprehensive, multi-disciplinary assessment for those frail, older people presenting at hospital reaps longer-term benefits and can avoid unnecessary entry to institutional care. However, it is vital that such patients are directed to the right specialty on admission and that the period in hospital be as short as possible so that the individual can return home, with the care and support they need to retain their independence. This is where good discharge planning comes in.

Data shows that people who go on to encounter a delay in their discharge have often endured far longer than average lengths of stay prior to being ready for discharge. The longer that length of stay the more likely the outcome will be a care home placement. This may be an indication of the complexity of needs for such patients that have necessitated a lengthy stay in hospital. However, it may also be that we have kept a patient in hospital for too long, trying to make them "a little bit better yet". Certainly, we have heard stories of hospitals "hanging on to people". Prolonged unnecessary stays in hospital will rarely improve physical or mental capabilities and recovery is better at home. Hospital should ensure that a patient is "medically optimised" so that they can go home at the right opportunity. Missing that moment can lead to a deterioration, a prolonged length of stay and a much poorer outcome.

A separate work stream looking at community hospitals has also received data that shows most patients in community hospitals entered via an acute hospital and that they go on to experience lengthy further periods of in-patient care. In many cases these people could have gone directly home and received further rehabilitation in their own home, re-engaged with family and their community.

We need to rebalance the approach to risk and consider ‘realistic care’. We know that in many cases, social care support is over-prescribed when assessed in an acute setting. Often the maximum package is sought, “to be on the safe side”. We are looking for the gold standard for people coming out of hospital, keeping them there if it is not available. Knowing the harms and knowing that people will want to be back home, we still choose to keep people in hospital. Because it is a choice. We could discharge them with “enough” support to get home rather than waiting for more than enough. People manage at home waiting on packages of care that are often greater than people stuck in hospital are waiting for. Local audits have shown that up to 40% of packages of care can be reduced through screening by social care staff.

The Home First approach invites all health and care professionals to ask the questions “why not home, why not now?” at every stage of the hospital pathway, from the front door, through admission, to discharge. It requires risk to be properly managed, putting the individual’s needs and wishes at the forefront and centre of any decision making. “Realistic Medicine” suggests that doctors often prescribe more for their patients that they would for themselves. The same could be said about assessments for community services. Unless absolutely necessary, ward staff should avoid any mention of care homes, so that the patient and family focus on returning home. The earlier the communication with the family on the discharge plan the better. Very few people want to go to a care home or would choose that option, and for those that do then these should be examined from the community rather than in hospital following a time of acute care. Everybody should be offered the opportunity to recover in their own home or in a more homely setting and transfers directly from acute hospital care to long-term residential care avoided wherever possible.

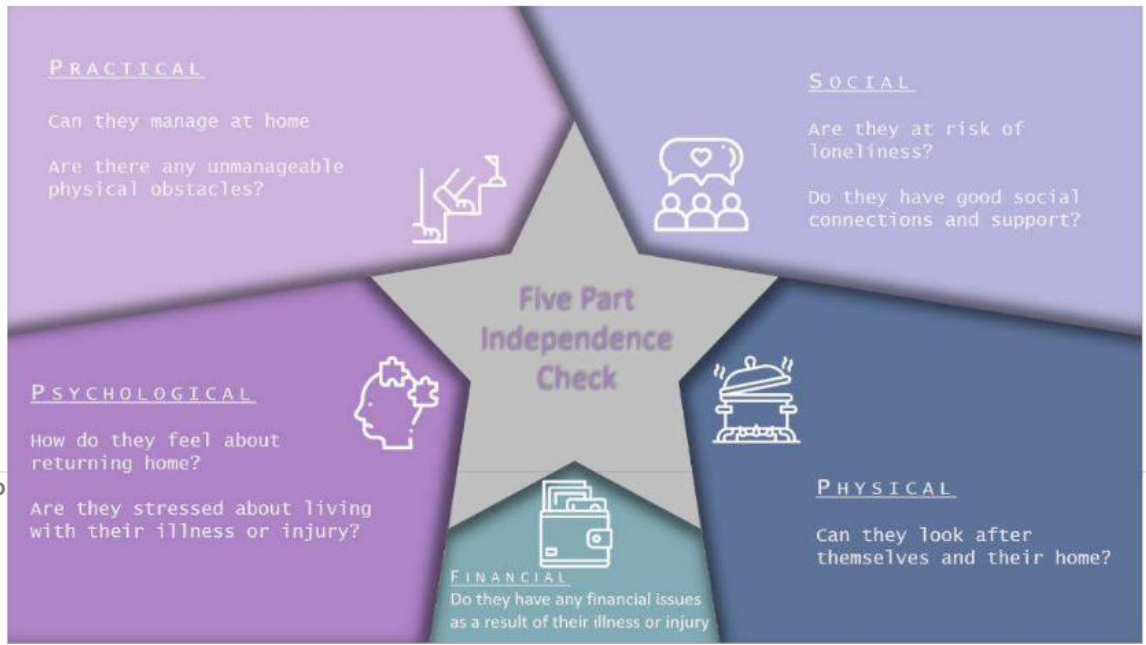
Mention of care homes can pre-judge the outcome of an assessment and when the suggestion has been made by medical staff, whose utterances will be trusted, it can be hard to change people’s mind-set that a care home placement is inevitable.
Ideally any assessment of long-term needs will be carried out in the individual’s own home where people are surrounded by their own belongings in a familiar environment. The work stream was unanimously agreed that an acute setting is the worst place to assess someone yet we frequently have a quarter of all delays in hospital waiting on the assessment happening. We need to move to a discharge to assess system where people are routinely discharged home, without delay, to be assessed in their normal environment, where they will be more confident and comfortable.

There will be cases where someone is unable to go straight home, when they will need a period of rehabilitation, with time to recover, and for a longer assessment to take place. Most partnerships have developed intermediate care beds where this recovery and recuperation can take place. It is important that these beds are dedicated for this purpose, that there is a clear criteria for using them and that each episode is time limited (while allowing some flexibility to realise every opportunity and potential for going home).

Not all partnerships use bed based intermediate care with some preferring this level of care to be home based. Such intensive support following hospitalisation should again be time limited to allow for handover to conventional care at home services. Professor John Bolton, of the Institute of Public Care, has worked with several partnerships in Scotland. He suggests a dedicated home from hospital service ("Transition Team"), arguing that a partnership should be able to predict how many older people will need intensive support to get them home from hospital and a multidisciplinary team be established solely for this purpose. Others with lesser needs would be cared for over the short-term by reablement teams and/or voluntary organisation. Although mentioning 'reablement teams' it is important to think of reablement as an ethos that should run through all care at home rather than a separate service.

Two of the biggest third sector organisations that support discharge have compiled reports based on their own experience and interviews with service users. The Royal Voluntary Service (RVS) campaign, '*Let's End Going Home Alone'*, called for a united effort to improve the support provided to older people leaving hospital. It showcased the central role volunteers and the public can play in supporting the NHS and revealed the positive impact that non-medical support can have on older people's recovery and well-being. The campaign had six essential principles (in the words of those who know):

A Red Cross report "*Home to the unknown: Getting hospital discharge right"*, sets out factors that illustrate the importance of considering how the wider context of a person's life, beyond their immediate, clinical needs, need to be accounted for in planning for



their discharge. It recommended a five-part independence check should be completed as part of an improved approach to patient discharge, either prior to discharge or within 72 hours of going home. This would help inform the setting of a realistic discharge date and would include assessing:

Partnerships say they are embedding a Home First ethos. But how many continue to admit when unnecessary and then pass people round the hospital system from specialty to specialty? How many continue to assess someone's long-term needs in an acute hospital? How many people transfer directly from an acute hospital to long term residential care? How many people continue to endure a delay in discharge? And in answering those, how many partnerships are really embracing Home First?

Key actions

- **Establish a multi-disciplinary agreed Planned Date of Discharge.**
- **Develop a "discharge to assess" model so that older people can be assessed for their long-term needs in their own home.**
- **Commission a dedicated "Hospital to Home" transition team to support older people home to be assessed and supported in the days after discharge.**
- **Utilise intermediate care "step-down" beds to provide a halfway house between hospital and home, for those who need additional recovery time before going home.**

Single Point Of Access

Acute staff should have a single point of contact/entry in order to readily access community support. This should apply at the front door, A&E or a component of the flow navigation centre, so that staff a can seek alternatives to hospital admission, and the back door, so that ward staff have a point of referral. This referral, for ongoing support in the community, should be as early as possible after admission, to alert social work and other community services to the probable need for support to discharge.

Referral should be early and appropriate, with the right level of detail that allows initial judgements to be made. Sometimes, if a patient is seriously ill with no likelihood of imminent discharge then there is little point in a referral. Otherwise though they cannot be too early, noting that in many cases currently they are far too late. Social Work cannot be expected to make immediate arrangements if the referral is on or after the ready for discharge date.

It is important to avoid referrals that are untimely (on or after the ready for discharge date), unnecessary (where the individual could go straight home for further assessment) or inappropriate (with suggested levels of care that raise expectations). We asked partnerships during the stocktake if referrals could be too early? The near unanimous response was that no, they couldn't and the earlier the better so that at least they had some warning of what might be needed down the line. What was helpful, in addition to the earliness of the referral, was ensuring the right level of detail was passed on. This should avoid any prejudgement of the referral itself ("patient needs a care home" was one often still reported), providing enough to justify the need for an assessment and start the process. Social work staff should if possible be part of the MDT making the decision concerning the referral.

Wherever possible, people should be supported to go home without delay so that a self-directed support assessment can take place when settled back home. This calls for an "interim assessment" at ward level to ensure it is safe for the patient to be discharged. Many partnerships allow ward staff to directly order home care for this purpose. This can speed up the discharge process but it needs to be carefully monitored, not just ordering the maximum allowed. Not only can this be expensive and difficult to match to service availability but it may lead to increased dependency. It also contradicts the choice and control of the patient.

There is no consistent method for making referrals. In some cases this is done verbally or by email, while many are made via the Patient Management System. The fact that patient management systems and social care databases are not linked remains an inhibitor. While consistency of approach would be beneficial there is not considered any advantage in dictating any one process over another and this should be left to local discretion. Referrals however should be of a good quality and standard to allow the right care to be sought. This is a requirement of the Care Inspectorate.

Likewise, many partnerships have social work teams based in acute hospitals, which could help foster closer relations with ward staff. Others remain convinced that in reach to hospitals from community based teams is better. There are advantages in both and it is for local partnerships to agree which works better for them. The key area is relationship building and shared understanding of roles. Having a common purpose in discharge planning speeds up the pathway and encourages ' realistic care.

The single point of contact should also be able to signpost the individual to other supports, such as those provide by third sector organisations, community supports, assistive technology, telehealth as well as statutory services

An alert on admission should be available to inform ward staff that the individual is known to social work. This could sit alongside an Anticipatory Care Plan (ACP) and Key Information Summary (KIS) and be available to those that need to access them.

Previous work identified the key factors in an effective integrated discharge hub:

The key factor is that it must be integrated and in some areas the discharge hub is solely an acute function managing beds and flow. It is difficult to know how a discharge hub can successfully operate without those who have major roles in discharging patients. So integrated is vital, as is the team being co-located with equal access to computer systems. They should be involved in tracking patients from the point of admission but only getting actively involved in non-routine discharges. Routine cases should be the responsibility of ward staff to discharge without delays.

Good examples describe a managed service network as an integrated team focussed on discharge planning.

That said, ward staff should have good knowledge of social work eligibility criteria which may only allocate support to those deemed critical or substantial. Some basic testing will be required on individual's competencies in mobility, feeding and toileting. This might also require the acceptance of shared assessment documentation.

The Delayed Discharge Expert Group had previously highlighted that partnerships making progress had identified a single, senior manager who works across integrated services and acute hospitals to tackle the delayed discharge problem, identifying solutions and driving sustainable change. The group chairs had written to all partnerships suggesting such an approach be adopted, and that taking a Home First approach, they should be empowered by Chief Officers and NHS and local authority Chief Executives, with sufficient authority, knowledge and experience to challenge poor discharge decision making and processes, including the management of risks. They should be able to cut through bureaucratic red tape and ensure there are no valid impediments to timely discharge home. In addition, they should ensure longer-term sustainability and that delayed discharge be seen as a collective responsibility rather than one person's.

What has previously shown as bad practice is where either the Hub or Discharge Manager becomes the solution to complex cases and everyone else abdicates their own responsibilities. Hospital staff must own and communicate that a patient if ready for discharge and therefore cannot remain indefinitely in hospital.

Key actions

- **Ensure community services have a single point of access.**
- **Where there is a clear need for on-going support on discharge early referral for community services must be made, well in advance of discharge.**
- **Referrals should contain sufficient but concise detail to allow timely and appropriate interventions.**
- **Ensure that people already receiving community support are discharged as soon as it is safe to do so, with re-starts of care and minimal cancellation of existing services.**
- **Sitting alongside an Anticipatory Care Plan and KIS, an alert could be available on admission to inform ward staff the patient is already known to social work.**

Rapid Response

There is a strong argument to be made for integrated “transition teams”. These would take the form of rapid response services and come under the banner of intermediate care and help the transition between hospital and home. These prevent admissions as well as facilitating discharge.

Many partnerships successfully operate dedicated teams which support hospital discharge, sometimes called hospital to home (H2H), not to be confused with clinical Hospital at Home. These teams, function to transfer someone home with enough immediate support to ensure their safety. These can often involve the third sector and can be anything from a safety check (is there food in the fridge, running water, heating, electricity?) to extensive care and support for the first 48 hours resettlement. Ideally a reablement approach should be taken. The third sector can also assist in schemes such as the “back home box” in Inverclyde.

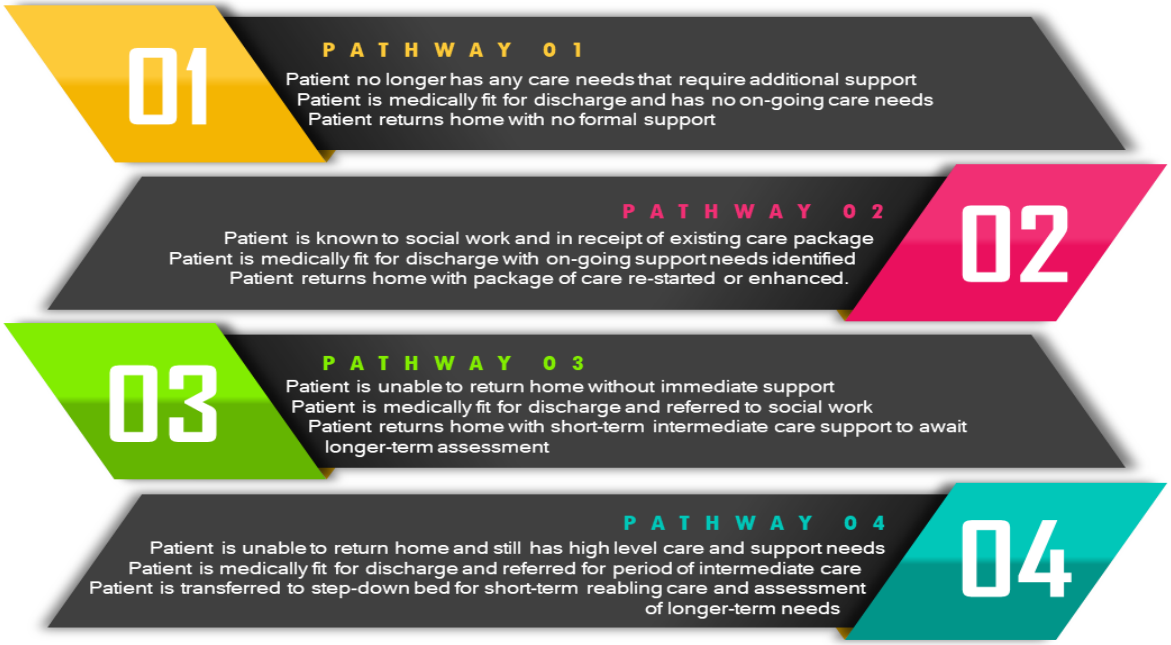
If the voluntary sector has been mobilised and more informal care and support has been provided, the requirement for statutory services may have reduced. There is a need to harness the general goodwill to fellow citizens, in terms of the informal care and support through wider networks of family, friends and neighbours and further develop support such as help with shopping, delivering food etc. There are excellent examples of this happening during covid, with community meals, community supports and befriending. A study by the Royal Voluntary Service demonstrated a halving of readmission rates, and enhanced confidence and satisfaction in recently discharged older people who had received support from volunteers. Other case studies have shown how local handyperson schemes have also reduced readmissions and improved support through simple housing adaptations.

The Red Cross research found that some people came home to houses that had not been prepared for their return – for example, with no hot water or heating on. Others returned to homes that were unsuitable or inappropriate for their recovery and their changed or changing needs. This ranged from struggling with a single step up to a front door, to feeling unable to get upstairs to the toilet.

Those who were sent home to conditions inappropriate for their recovery faced increased risk of falling, as well as other hazards, once discharged from hospital. This, of course, has a significant impact on a person’s recovery trajectory. For a person living with frailty, falls are not the only driver for hospital admission, but we know that delayed discharge has negative influences on longer-term recovery and increases the likelihood of re-admission.

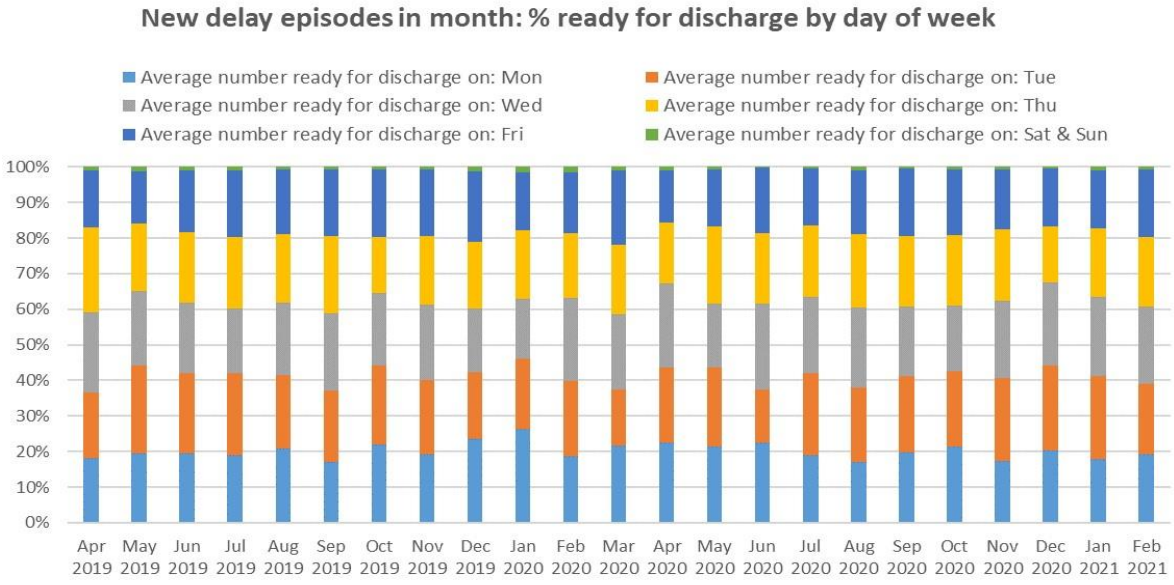
Discharge to assess (D2A) is varyingly described as an ethos, a team or service. It is about ensuring someone is safe to go home so a full assessment of their long-term needs can take place within their own environment, rather than in an acute hospital.

Several NHS Trust's in England use a diagrammatic "pathway" model, such as the one below.



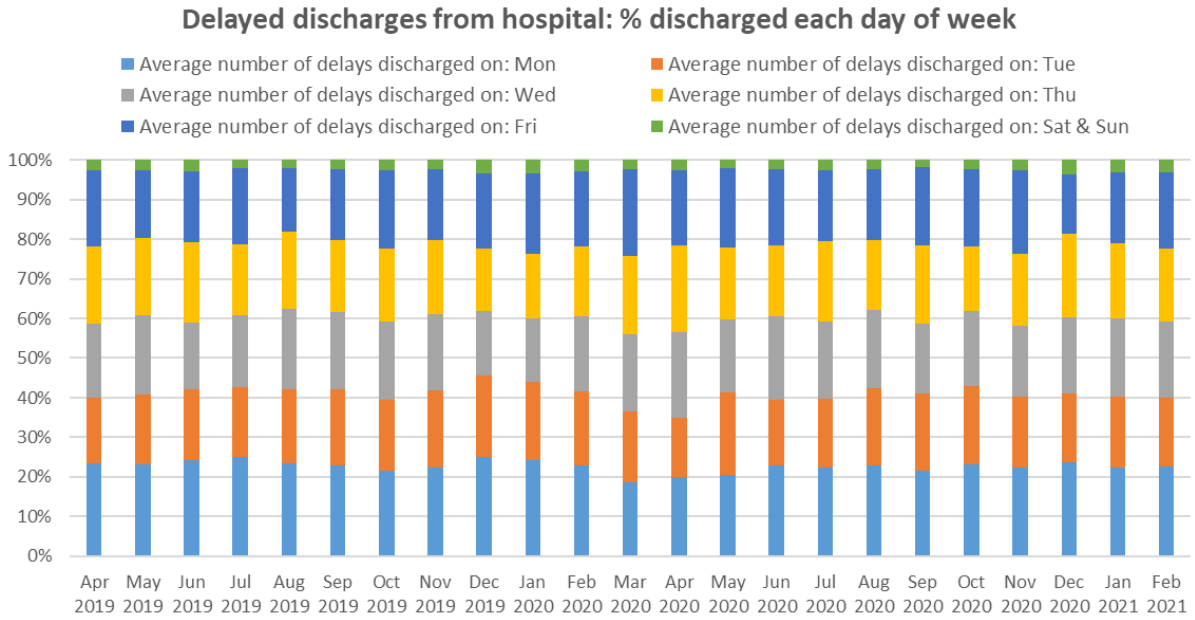
Patients on pathway 01 are routine discharges with no formal support needed and patients on pathway 02 discharged home with restarted support. Transitional intermediate care support comes in for pathways 03 while some sort of interim move might be needed for pathway 04.

Seven day working is also necessary for providing a rapid response in preventing needless delay in discharge. Previously thought of as social care being unable to match the NHS in 24/7 working, data has shown the reality of an absence of senior clinical decision making within hospitals being the major constraint.



Often social work teams have been stood up to take referrals over the weekend but none were received. That said, there is a reluctance of private sector providers to accept new clients over the weekend with a preference suiting care homes and care at

home rotas for people to be discharged on a Monday. While the previous chart showed the day of decision on readiness for discharge, the following chart shows the actual day of discharge. Both charts only include delayed discharge patients and show little activity over the weekend. It is acknowledged that routine discharges and decisions are more likely across seven days.



True seven day working to become a reality needs all parts of the system to be geared up to do their part each day.

Key actions

- **A dedicated team 'Hospital to Home' could be established in all areas, which includes third sector and or their local community support.**
- **Discharges and discharge decisions should be made across seven days.**
- **Use Criteria Led Discharge to allow decisions over the weekends or senior clinical decision makers should support discharge planning**
- **The anticipated default position for all older patients should be that they (ultimately) return to where they were admitted from.**
- **Private sector providers both care at home and care homes should be commissioned to accept referrals over 7 days.**

Intermediate Care/Community Hospitals

The Community Hospital Short Life Working Group (SLWG) was established to investigate the current provision and use of community hospitals and Intermediate Care across Scotland, and gather examples of best practice in their use from across the UK.

The group discussed the current operation of community hospitals from their perspective, and considered what good practice might look like for the differing models in operation.

It was recognised that the operation and use of community hospitals varied across the country, and that there was not a one size fits all example of good practice due to this variation. The group agreed to the development of a set of Key Principles that could inform service development and improvement.

Given the time available the group has not had an opportunity to look at the provision of Intermediate Care in care homes in any detail. However, the group felt that the key principles within the Intermediate Care Framework were still fit for purpose, although the overall Framework did possibly require a review.

Currently, there is no national data available for Intermediate Care, whether provided in a hospital, care home or a person's own home. Work needs to be carried out with PHS and local partnerships to develop a national dataset for Intermediate Care services to allow us to track developments.

The report includes a number of recommendations for the Scottish Government and Key Actions for HSCPs to help make optimum use of their community hospitals. Further toolkits and guidance will also be developed.

Recommendations and Key Actions can be found in the Community Hospital and Intermediate Care Report [add link].

Staff Profile and Staff Mix

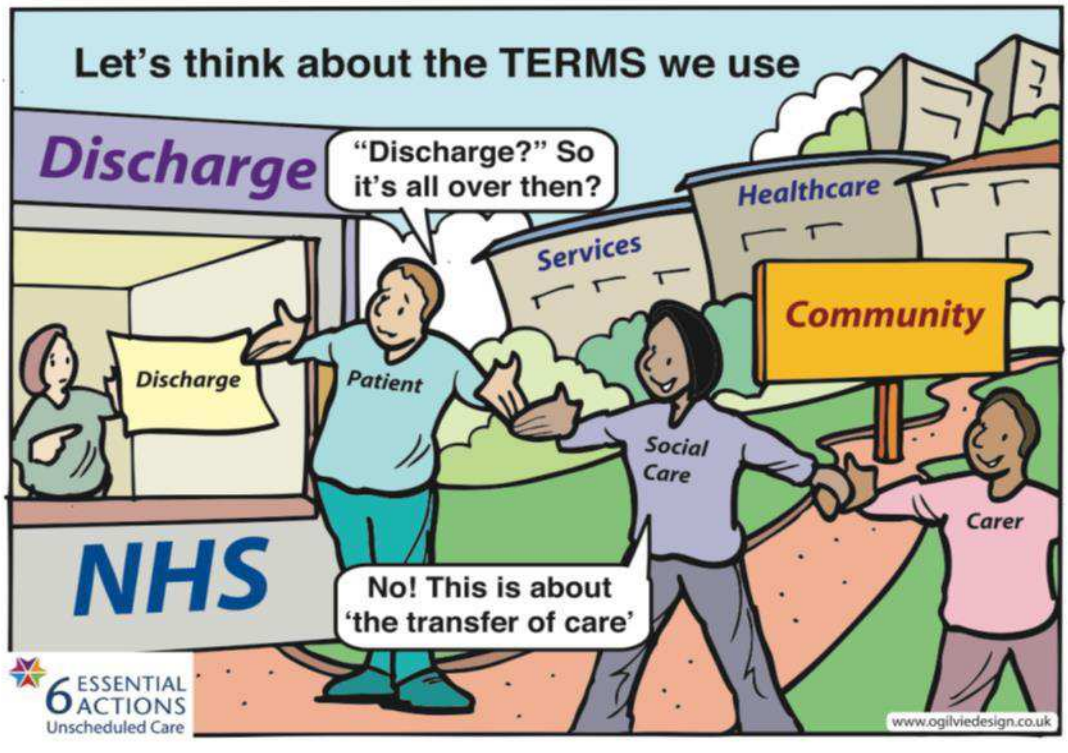
Most teams would be described as multi-disciplinary with a necessary mix of staff and disciplines. These will vary from team to team but will usually benefit from having easy access to specialist expertise such as consultant geriatricians.

The aim of good discharge planning is to ensure that patients are discharged from hospitals safely and in a timely way. This approach involves multiple people who have a vested interest in a person's care arrangements pre and post discharge from hospital.

Having an effective framework of patient-centred multidisciplinary and multi-agency teamwork manages all aspects of the discharge process and ensures the patient receives continuity of care as they are transferred from one setting to another.

We should not underestimate the importance of engaging and including the patient's family and carers from the offset as they know the patient best and can lend a helping hand with the patient's recovery. A family's ability, availability and willingness to provide a level of care is important for the wellbeing of the patient.

Red Cross research revealed that many of the challenges in co-ordination between teams stemmed from the clinical handoff, with the communication of patient needs breaking down between ward staff and those working on discharge. The person or people responsible for discharge differed from one hospital to another. Often discharge planning was tacked onto the patient journey at the end, rather than being integral to decision-making while a patient was on a ward. The lessons learned report highlighted this issue with an animation on its cover.



As with any collaborative working, staff involved in the discharge process need to know their own roles and responsibilities, while respecting those of others in the team. It is

important to work as “one team” and to work together towards agreed, shared goals with a common sense of purpose. To achieve this, we need to identify the key roles and responsibilities involved in discharge planning arrangements. The Delayed Discharge Expert Group agreed the following descriptors of individual roles:

Patient, family and carers
• Should be fully engaged in the discharge process from the earliest stage • Should be given information, advice and support about the discharge process, including access to independent advocacy services • Support the need for timely discharge and avoid unnecessary barriers and delays
All staff
• Should be consistent in the messaging that patients should go home and that remaining in hospital is not an option • Ensure the involvement of family and carers in discussions about care needs • Agree a Planned Date of Discharge • Work on discharge arrangements towards the planned discharge date and not from it
The clinician
• Assess when someone is clinically ready for discharge (as part of MDT process) • Support sensitive discussions around options to go home or to intermediate care if home is not an immediate option • Take a positive attitude to risk enablement and management • Ensure timely production of Immediate Discharge Letter • Ensure prompt arrangements of any discharge medicines • Ensure that all infection prevention and control measures are followed per HPS guidance
Nursing and ward staff [AHPs?]
• Ensure effective and inclusive engagement with the patient, family and carers throughout the discharge process • Senior Charge Nurse will use their expertise in discharge planning in line with Home First principles and practice • Ensure discharge planning starts as early in the process as possible • Liaise with social work staff to ensure early notification of people who might

need on-going support • Provide information and advice to ensure people have realistic expectations of care • Keep patients as active and stimulated as possible to avoid deconditioning
Social Work staff
• Ensure discharge planning starts as early in the process as possible • Support family and carers through the process • Commission provision of on-going community support where required • Ensure a re-ablement approach is taken and avoid unnecessary delivery of care • Lead the completion of assessment of ongoing need and supports, post-discharge from hospital

When talking about multi-disciplinary teams, or any team for that matter, team working is of the utmost importance. Much of that is down to leadership and relationships, but in any team it is vital that each individual knows what their role is. Equally important though is knowing others' roles, and their responsibilities. Team working can break down when people step outside of their own role to try and do those of others.

Some blurring of roles can be good. However, you would expect medical advice to be provided by a medical practitioner and the same principle applies to social care. Advice around social care needs to be provided by social care professionals. There are many examples of integration bringing teams together which have blurred the boundaries between roles. However, good practice in this theme is perhaps better described by a poor practice example, heard at a daily huddle. This involved discussion on patients awaiting "assessment for a care home placement". The assessment hadn't taken place, or been asked for, but the narrative had formed that a care home place was needed, prejudging, and also potentially prejudicing the outcome of the assessment.

The hospital is the operational ground for Home First and the main site where a cultural shift will be necessary. As such hospitals need to ensure all staff, including clinicians, nursing, AHPs and social care workers, fully embrace the philosophy and have robust communication and education plans in place. To effectively realise a cultural shift, those who will be most impacted by the shift need to be engaged throughout the implementation process.

Clinical Staff

Clinicians in the hospital and community should be targeted separately due to their direct involvement in patient care and planning. Although part of a multi-disciplinary process, the ultimate decision regarding a patient's discharge rests with the clinician. For Home First to be successful clinical support is critical and any change in process or culture must be owned by the clinician for it to be accepted by the patient, family and wider multi-disciplinary team.

Nurses
Nurses are often the health care providers that spend the most time with patients, therefore it is critical that the nursing team is fully aware and supportive of the Home First philosophy. Nurses are also a key point of contact for the patient and family. They can respond to their questions and reassure them of their ability to manage at home. In working with patients, nurses can also identify barriers and challenges and work with colleagues to identify potential solutions. Nurses often serve as a link between physicians, allied health professionals and the care providers. They are a conduit for knowledge transfer, and their ability to provide information as well as provide support should be capitalised.

Allied Health Professionals
While allied health professionals (AHPs) is a broad term that includes many health care professionals, for the purposes of this guide, allied health professionals refers primarily to physiotherapists and occupational therapists, as they are the AHPs most involved with Home First processes. Furthermore, the Home First philosophy can be applied to other types of care including rehab, mental health and convalescent care where allied health practitioners may act as primary care givers.

Social Work and Social Care
Multi-disciplinary working and close collaboration is to be encouraged at all times. While diagnosis, treatment and hospital care and recovery are the rightful domain of healthcare professionals, on-going social care needs should be led by social work and social care professionals who have in-depth knowledge and experience of what can be safely provided in the community.

Primary care
Primary care is often the first contact for patients with an undiagnosed health issue and also provide continuing care for various medical conditions. They can exert great influence on patient choices and experiences as patients tend to heavily rely on and trust in the advice and recommendations of their doctor. GPs should also actively monitor their patients while they are recovering and receiving care at home to ensure timely recovery and avoid unnecessary readmissions to hospital.

Clinical Leadership
Clinical leadership's support for the philosophy is required to effectively engage clinicians and allied health professionals hospital wide. Clinical leadership can provide advice on how to best reach clinical audiences and can also be at the forefront of physician and allied health communication and education.

Key actions

- **There should be a designated senior person(s) to manage delayed discharge performance, with oversight of the Discharge Hub (where applicable), delegated authority and funding to make instant decisions,**

respect and authority to be able to challenge poor decision making and control of the data.

- **Everyone should have a clear understanding of their own roles and responsibilities and those of others.**
- **Multi-disciplinary should have the necessary skill mix and ready access to expert professional advice.**
- **Teams should be well linked with co – location as an ideal. Where this is not possible, regular 'virtual' meetings across teams should be the ideal.**

Whole System Approach

All health policies aim to be person-centred, putting the patient at the heart of everything we do. Yet very often delayed discharges distil down to numbers and trying to reduce the number to ease pressure on other parts of the system. It is worth recalling a previous Health Minister saying “action should not be motivated merely by beds, budgets and statistics but by the need to provide person-centred solutions to the problem. This is not just an exercise in reducing numbers – it must be about improving lives”. Delayed discharge is a whole system problem that needs a whole system solution. Yet it is often the subject of blame, where it is seen as someone else’s fault, someone else’s problem that someone else needs to fix.

The early stages of the pandemic showed what can be done. Everyone in it together, with shared goals and a common sense of purpose. People working collaboratively between teams and professionals. This sort of partnership working across the whole system needs to become commonplace.

Discharge should not be seen in isolation, it is merely a part of the whole journey, a journey that starts before admission. The simplest way to stop a delayed discharge is to avoid the admission in the first place, acknowledging that for a frail, older person a short admission to a geriatric specialty might be want is needed to get someone back on their feet and regain their confidence. However, evidence shows that failing to access the right specialty can add days to the length of stay in hospital, a longer length of stay leads to someone becoming delayed in their discharge and the longer that length of stay becomes, the more likely a care home placement will be the end result. So we need to address the whole pathway.

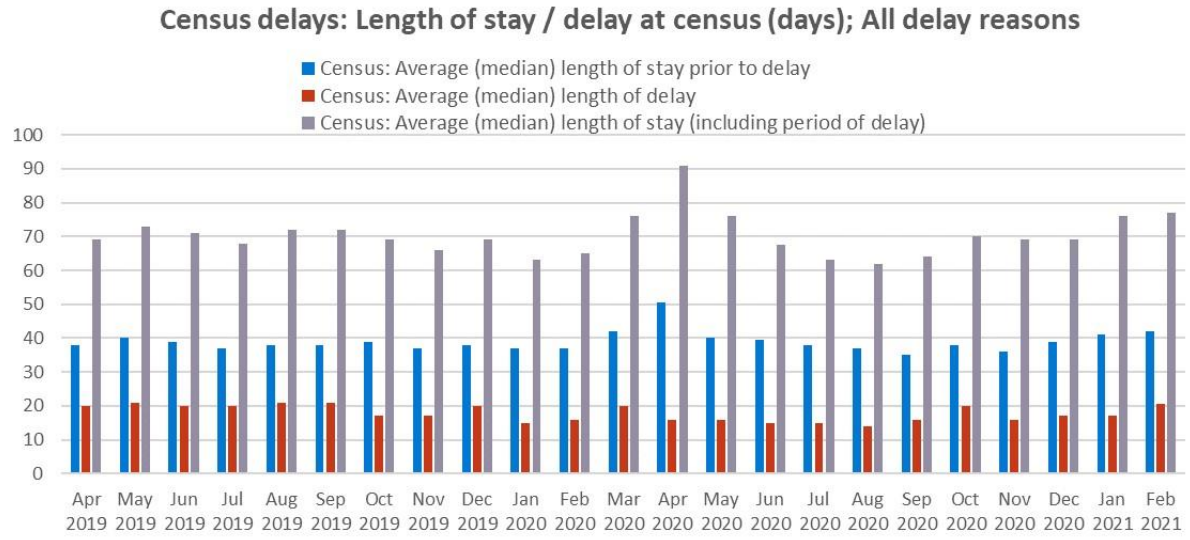
Most partnerships have unscheduled care boards or working groups, discharge planning should be a key action of these groups and this should be reflected in action plans.

The best partnerships track their patients through this journey, knowing when they have been admitted and proactively planning for their discharge. It is important that hospitals play their part. We know that people will lose muscle capacity and general life-skills the longer they are bedded.

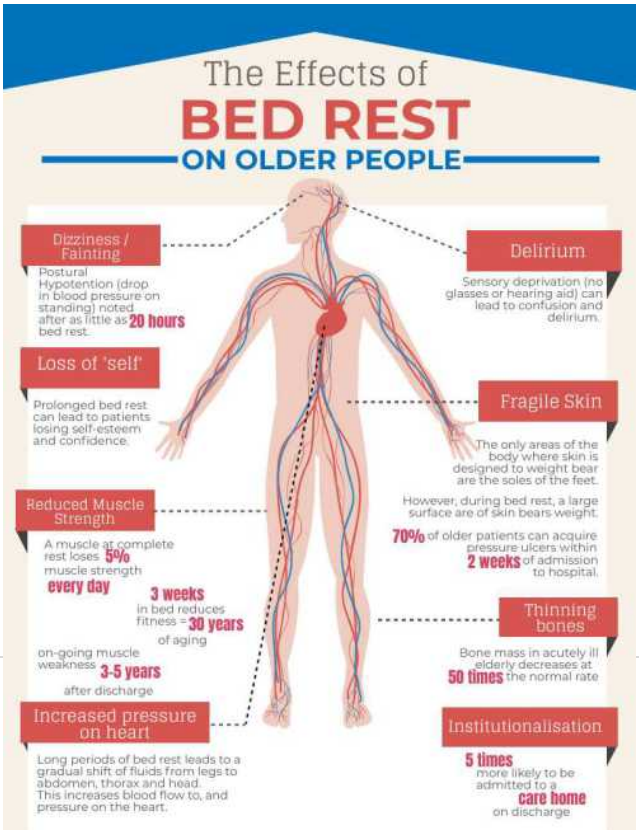
That is not to say people should avoid hospital. The use of acute hospital beds for older people can be reduced through avoiding emergency admission and/or reducing excessive lengths of stay. Key to this is ensuring frail, older people are seen in the right place by the right team. The SCoOP report on acute hospital outcomes stated “every one day spent waiting to get to a specialty bed adds three days to overall length of stay. Priority must be given therefore to creating easier access to specialty beds for older people with frailty”.

When older people are admitted to hospital they are often needlessly passed from doctor to doctor before they are seen by a geriatrician, to discover that what is wrong with them is that they are old and frail. Healthcare Improvement Scotland's 'Frailty at the Front Door' collaborative work has already shown results in reducing lengths of stay.

PHS provided data on average lengths of stay, including the periods before and after the ready for discharge date. Much is known through delayed discharge data about the length of delays but it was striking how long people had been in hospital prior to being ready for discharge.



Work in one partnership found the average length of stay in acute hospital was 5.1 days. For patients who became delayed discharges, the average went up to 47 days. The work uncovered the bulk of that length of stay (on average 30 days) was before they were deemed ready for discharge. In such circumstances the patient will have become deconditioned to the extent he or she may never return home. That deconditioning will rarely be down to the presenting illness but rather to the unnecessary time spent in hospital. One of the health and wellbeing outcomes states "people using health and social care services are safe from harm". The sad truth is that for older people, it may well be that the longer we keep them in hospital the more harm we are causing.



We have produced a poster that many clinicians have taken to display in the Emergency department and has been regularly tweeted.
It is an uncomfortable message but one that the Health & Sport Committee reproduced in it a report sub-headed

“when is hospital bad for your health?”. We have shown it to older people’s groups who have all suggested this be shared more widely and perhaps it could form the basis of a public information campaign. We have a number of similar graphics we use.
There are already a number of campaigns aimed at reducing the effects of bed rest. The best known is the end PJ paralysis campaign, with the slogan “get up, get dressed, get moving” in order to “get better and go home”. We need to change the culture of people in our hospital away from being passive recipients. We suggest people bring their night clothes and reading material if coming in to hospital. One of the first things ward staff will do is give the patient a menu and ask them to tick their meal selections for the next few days. Everything is geared up for a long stay rather than a quick turnaround and go home.

Key actions

- **To ensure older people do not become dependent or disabled in hospital a reabling approach throughout the patient’s journey through, and out of, hospital should be adopted.**
- **More co-ordinated approach to rehabilitation and reablement should be taken, encompassing hospital and community staff, aimed at providing this in the home wherever possible.**

Outcomes And Data

The working group considered a range of data, both existing and desired, which were subsequently discussed with Public Health Scotland.

Data and Outcomes	PHS Comments
Increase in number of discharges without delay	• Data to support this measure is included in current data output. Note that a delay is counted only if it was immediately prior to discharge. • Data caveat: Need to acknowledge differences in completeness of SMR hospital discharge data as this affects some HBs more than others.
Reductions in delays to discharge and length of delay.	• Data to support reduction in delays and length of stay and length of delay measures are included in the current data output provided.
Reduction in bed days occupied	• Data to support this is included in current data output.
Increase in discharges home	• Data to support this is included in current data output for delayed discharges. Further development would be required to analyse this for all hospital discharges • and dependent on data quality on discharge destination.
Increase in planned referrals / Reduction in unplanned referrals	• Data to support this is included in current data output, comparing date referred to social work before or after the ready for discharge date.
Social work assessments for long term support being carried out in hospital	• Not sure how reduction in social work assessments carried out in hospital is intended to be measured? • Future requirement.
Reduction in inappropriate admissions	• How would inappropriate admissions be measured? Data is not currently included in the current data output.
Reduction in AWI through 13za	• Nationally PHS don't have data to support this – how would this be measured?
Measurement of delays due to equipment	• Not specifically identified in current data output. What measures would be required here?

First and foremost, the data needs to be accurate and agreed ("single, shared version of the truth") and this is not always the case. This can often lead to disputes about who is truly a delayed discharges and debates about the correct reason code to use. The original delayed discharge expert group report in 2011 said that "the correct data is the intelligence that partners need to solve the problem". They emphasised the importance of that data being accurate. What gets measured, gets managed.

Several partnerships asked for training on delayed discharge data collection. PHS has recently concluded a consultation on the presentation of the data and will shortly announce any changes. This consultation included a proposal to incorporate s subset of codes for patients going through the adults with incapacity legal process, to provide a better understanding of where in the system delays are occurring.

Following the consultation, the Scottish Government and PHS should consider what training might be necessary to ensure a consistent understanding of the data definitions and coding. As examples, one lengthy delay was queried to be told "that patient died three months ago" but had remained on the data system as ready for discharge. In other cases, medical staff were not allowing the discharge of patients considered ready for discharge. There needs to be accurate recording of data, verified locally and signed off, as per the current PHS guidelines, by the HSCP Chief Officer or nominated representative. Some areas used the Discharge Hub or Daily Huddle to agree the data. Whatever method is used it is important to have a verification process built in to regular working practices. A simple test might be to ask "if everything was already in place, could the patient be discharged today". If the answer is yes, and they are not discharged, then they will likely be classed as a delayed discharge whereas that would be unlikely if the answer is no.

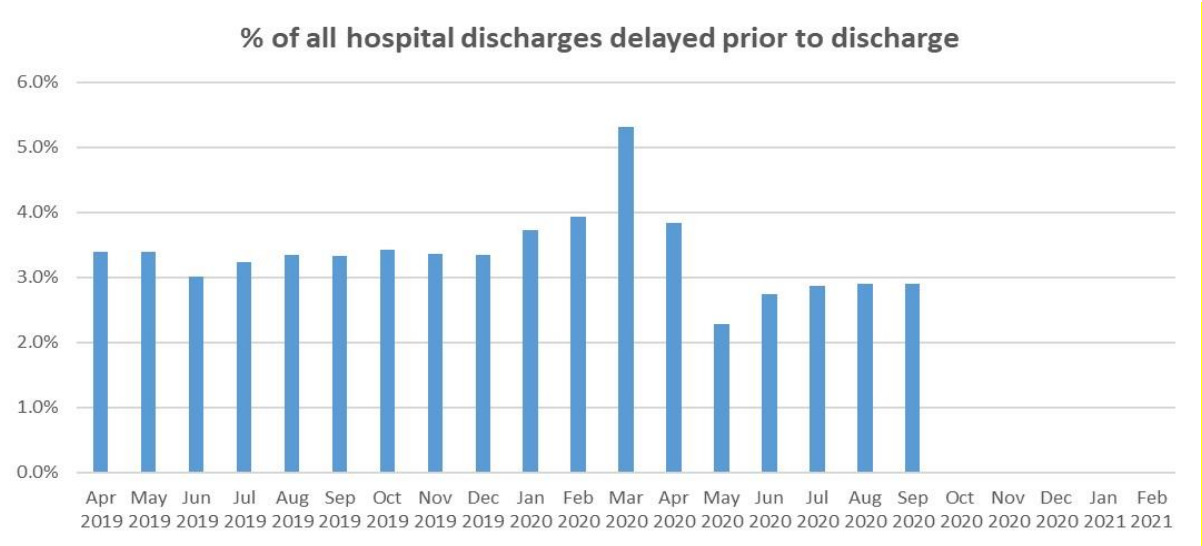
Where an out of area case is identified then the Health Board of treatment and HSCP of residence must be notified as early in the patient's journey and once likely on-going care and support needs have been identified.

It is also important that the code accurately reflects the reason for delay. For example, for planning purposes it will be important to know if someone is waiting for a specialist dementia bed rather than a nursing or other residential care place. Equally, it is important to separate delays awaiting equipment or adaptations from other care arrangement codes. It is particularly important to correctly code those delays for which the main delay is a patient/family/carer related issue. Some partnerships admitted that if there was any dispute or if the reason was unknown, code 11A was the default code, so presenting an inaccurate picture of the assessment delays.

The group considered data on referral dates and whether this was before, on or after the ready for discharge dates. In some cases, this field is not being completed and others defaulted to the ready for discharge date. This is important knowledge to have on how the system is working, so vital that this is filled in correctly. We will need to consider how to collect, manage and monitor the effective use of Planned Date of Discharge going forward.

Among other data considered, of particular note was the information on lengths of stay (prior to and after readiness for discharge) linked to the discharge destination (home or placement). This raised a lot of discussion within the group and would undoubtedly do so among partnerships, so this data should be shared more widely and a summary published within PHS's annual report on delayed discharges.

Also of interest was the data on the proportion of all discharges that encounter delay. Given the relentless focus on delayed discharges there was some surprise that the latest available month (and this data had a time lag of around 6 months) showed 97.2% were discharged without any delay in their discharge. In addition, there was some surprise that only 2.8% of all discharges were delayed, although this varied from 0.3% to 8.0% between partnerships. The group considered this a more meaningful statistic than just a census total of delays and that it allowed the delayed discharge issue to be seen in the wider activity context. If targets were to be considered then this might better reflect continuous improvement, increasing that proportion from 97.2% by incremental percentage points.



Key actions

- **A rigorous approach must be taken to the accurate recording and coding of patients encountering a delay in their discharge.**
- **Chief Officers, or their nominated representative, are ultimately responsible for validating local data submissions.**
- **Patient Management Systems should have a field for Planned Date of Discharge**
- **Partnerships should accurately record PDD to monitor implementation.**
- **The date of referral should be recorded and monitored to ensure this is as early possible and practicable.**
- **The additional data made available to the work stream should be made available as management information to partnerships, and a summary published within PHS's annual report.**

Communication

We talk about communication in several guises. Communication between professionals and the patient - involvement of family and carers in these discussions; ensuring necessary information is available in different formats; making sure conversations are realistic and manage expectations; managing choice and brokering constructive conversations. Communication between agencies - early referral, with the right amount of details; everyone knowing their roles and responsibilities.

We also need to embrace the changes during the pandemic, making best use of digital technology. Daily face to face, multi-disciplinary huddles are no longer needed with everyone in the same room when technological alternatives have been so successfully used.

Good communication and joint working are pre-requisites for a well-coordinated and timely patient journey from pre-admission through to their discharge home or to a permanent place of residence.

Section 28 of the Carer (Scotland) Act 2016 placed a duty on Health Boards to involve carers in the discharge planning of patients who may require on-going care after discharge from hospital. Carers play a significant role in helping people with health and social care needs return home after a hospital admission. They know the people that they care for better than anyone else and can provide information about the person's needs and circumstances beyond medical conditions or physical needs. This means discharge planning can be more comprehensive and may reduce the likelihood of the person being readmitted to hospital

From the outset of a patient being admitted to hospital, the multi-disciplinary team, along with the patient, family and carers need to have a clear expectation of what is going to happen during the stay in hospital. Discharge planning conversations are a critical component for patients when they are admitted to or leaving the hospital setting to ensure a smooth, safe and supported transition from hospital to home. Effective and timely involvement of patient, carer and family members from the outset is therefore required as they are central to the decision making process being productive. This will also include POA / Welfare Guardians for patients who lack capacity.

Communication and engagement between primary, secondary and social care is required to ensure that, prior to admission and on admission, each individual receives the appropriate care and treatment they need. This approach should ensure that patients are then discharged from acute and non-acute inpatient facilities in a safe and timely manner and to the appropriate setting.

Discharge planning conversations are a critical component for patients when they are admitted or are leaving the hospital setting. Comprehensive discharge instructions are necessary to ensure a smooth transition from hospital to home. Effective and timely involvement of patient, carer and family members from the outset in discharge planning

is required as they are central to the decision making process being productive. Patient, carer and family should be prepared (physically and psychologically) to transfer home or to another setting and this will be impacted by the level of timely communication of information regarding the patients discharge. Relevant parties involved in the decision making process should feel engaged, informed and communicated with from the first day of care/admission. Part of this process should involve the multidisciplinary team where appropriate or hospital staff setting and recording the Planned Date of Discharge on the day of admission or as soon as possible after admission and this should be communicated to the patient and all parties. Any change to this date should be recorded in the patients notes and relevant parties notified. 'Near me' can be used to have communication with family and carers, often there is anxiety from families when they haven't seen their loved one for some time due to covid restrictions.

Hospital and social work staff can also make clear and communicate that discharge will be organised as soon as the patient is clinically appropriate, with all parties clear that remaining inappropriately in hospital and people will not be able to stay in a bed after the point where this is clinically necessary. For people leaving hospital this should mean that (where it is needed), the holistic assessment and organisation of ongoing care will take place when they are in their own home. Where it is not possible for someone to be discharged directly home, a period of intermediate care should be considered and discussed with the patient.

While stressing the importance of good communication with patient, families and carers what is not said is equally important, so ward staff should carefully guard against saying anything about post-hospital support that might inappropriately raise expectations. The key messaging should be about the patient going home. Hospitalisation is a stressful time for older people and their confidence in their own ability to live independently must not be eroded.

Although the potential for recovery should always be examined and every opportunity to go home maximised, there will be occasions where someone will transfer directly to a care home. This is a life-changing situation for people, who may never see their own home again. People have a statutory right of choice of accommodation, as to where they will go on to live. This process should not unduly delay discharge and choices have to be realistic. Guidance is clear that choices of care home should be suitable; available; at the usual weekly rate; and the home has to be willing and able to provide accommodation.

On occasion, some patients can go home without understanding critical information about their hospital stay, leaving them at risk for hospital readmission. However, efforts have been made to improve discharge education with a focus placed on increasing communication between care provider and patient. Some HSCPs have introduced patient_centered educational materials in the form of discharge information leaflet/guide for patients, their families and carers. The leaflet, given to the patient on or prior to admission, outlines the process of discharge planning and how the patient's needs are assessed, moving on process etc. Some areas have seen a simple, professionally set,

self-managed programme of rehabilitation improve recovery and reduce readmission rates.

Consideration must be given to the requirement for each board/partnership to have a discharge planning communication plan embedded into their discharge policies. This plan will be based across all acute and community sites and should inform leadership teams and staff of what works well and what areas can be improved in relation to effective discharge planning for the patient.

One of the major factors influencing the quality of discharge is the preparation made in the hospital prior to the patient's discharge home. Effective communication with patients and between staff and community staff, to include a detailed discharge plan is critical to the achievement of this.

Information technology has remained a barrier for systems ability to talk to each other. Yet some partnerships have overcome accessibility problems, with NHS Greater Glasgow & Clyde now having an agreed electronic referral system. It is important to stress that technology should not replace personal contact. Nearly all partnerships expressed the importance of teamwork, with co-location of staff being seen as vital in helping to bond the team together.

While there is unlikely to be a one size fits all solution, we should add details of such solutions to a library of help, support and advice, readily accessible by all partnerships.

It is usually beneficial to share pertinent information with families and carers so that they are aware of how they might contribute to safe and timely discharge. However, it is also worth pointing out that while it may sometimes appear to be obvious that a patient is happy for information to be shared with family, this should be checked to avoid any misunderstanding.

Key actions

- **The key message is that no person should suffer unnecessary delay in their discharge from hospital.**
- **Communication should be clear that the expectation is the patient goes home – "the best bed is your own bed".**
- **Active participation of patients and their carers is central to the delivery of good discharge planning.**

Enablers

Technology Enabled Care (TEC)

Telecare (including community alarms) can be an important part of the care and support provided on hospital discharge.

Like any other care or support, the need for telecare should be considered as early as possible, with early referral to the telecare service. With more than 20% of people aged over 75 receiving telecare, many patients will already receive a service, and it may be that their telecare package will need to be restarted, reviewed or enhanced to support hospital discharge.

There should be staff within the multidisciplinary team or discharge hub, including social work or social care professionals and occupational therapists, who are able to assess for, and request community alarms and/or telecare. A specialist assessor from the HSCP TEC or telecare service may need to be involved in the assessment of patients with more complex needs. There should be an identified person who will facilitate communication between the hospital and the TEC service.

As part of discharge planning, the person undertaking the assessment for technology enabled care should:

- have a good understanding of telecare and what can be offered – to prevent over, under or inappropriate provision of telecare;
- be aware of ethics and issues of informed consent regarding telecare (for example for people with dementia);
- provide the level of information the telecare service requires to install equipment and initiate the service – this will often involve liaison with family and carers;
- provide the patient, and where appropriate, their family and carers, with information about the service so they fully understand they will have devices in their home that connect to an alarm receiving centre, and that they will need to nominate key holders or contacts;
- inform the patient and where appropriate, their family and carers that a charge for telecare applies. Almost all telecare services in Scotland charge, however some offer a free trial period.

Hospitals that discharge patients to more than one HSCP area should be aware that the telecare service offering may vary between HSCPs.

In some areas and/or in some situations, telecare devices can be installed prior to discharge, with the assistance of the patient's family or carers, who will be instructed on how the devices work, and the service operates. However, in some cases the installation will be within 24 hours of discharge. To enable this to work effectively, telecare services should be notified of any changes to the discharge date or time. Together with early referral, this is key to preventing telecare installation delaying

discharge. Many telecare services prioritise referrals to support hospital discharge, but sufficient notice is still required.
Examples of what's working well:

- Telecare awareness training for hospital staff, provided by the HSCP telecare service.
- A free initial trial of telecare – to remove a barrier to uptake.

Lifestyle Monitoring

Lifestyle Monitoring is a digital activity monitoring system that can help care professionals complete objective and evidence-based assessments, enabling people to receive the right level of care and support. It involves installing discreet door and movement sensors around a person's home for a limited assessment period, providing an overview of their daily activity, and helping professionals make proportionate care decisions.

Lifestyle Monitoring is available in most areas, and can be a useful tool to support Discharge to Assess. The HSCP TEC service should be contacted for more information, and for local referral, installation and monitoring arrangements.

Remote Health Monitoring

Remote Health Monitoring is the use of digital remote monitoring technology to enable patients outside of hospitals to receive, record and relay clinically relevant information about their current health and wellbeing. It is used to guide selfmanagement decisions by the user / patient and to support the health and care team in their treatment and care planning.

Restarting or introducing remote health monitoring of blood pressure, COPD and diabetes should be considered in appropriate situations.

Near Me

Near Me is a video consulting service. It is a web-based system the helps public sector providers offer the option of video calls. Near Me can be used to facilitate all people involved in a patient's discharge – professionals and families and carers – being active participants.

Apart from internet access, all people need to use Near Me is a suitable device and the Chrome, Edge or Safari web browser. Computer users will also need a web camera (usually built into laptops) and a headset or speakers.

Equipment

To ensure seamless arrangements for the discharge from hospital settings, it is important that a range of staff within the hospital (occupational therapists, physiotherapists, liaison nurses, and staff within multi-disciplinary discharge teams) can assess and order directly, equipment for 'safe discharge', for their patients. It important that these staff are supported to provide all aspects of the assessment role including

follow-up and conclusion of the assessment following provision. This may be supported by in-reach models.

Ongoing community needs, require to be referred to appropriate community services so these can be properly assessed in the context of the person's home environment and as part of their recovery plan. Therefore, although hospital based staff can access a wide range of equipment, they will only provide what is appropriate to support the service user to safely return to the community.

In addition, it is essential that clear pathways are in place to allow hospital staff, to refer to relevant community staff for the assessment and ordering of equipment for more complex, ongoing needs i.e. tissue viability, seating. Ideally, this should ensure that one assessor will take on the provision of all relevant equipment for discharge to avoid duplication and multiple deliveries.

In the case of tissue viability needs, it is important that hospital-based referrers avoid over-prescription for those patients with non-complex needs, and services agree provision of simple solutions, to ensure a safe discharge and allow for a review of needs and more specialist provision, if required, once the person is back in their home environment.

There will also be circumstances where joint working should prevail, and the expertise of the hospital based practitioner should be utilised alongside the skills of the community professional to meet the needs most effectively e.g. service users with Spinal injuries, Children, and/with complex needs, or requirement for equipment for use within planned adaptations related to discharge.

It is hoped that this approach will greatly support the more effective provision of equipment and also ensure the opportunity to clarify other wider needs related to the home environment e.g. need to discuss re-housing and/or the need for adaptations. An example Protocol has been developed to assist local services clarify roles and responsibilities for the provision of equipment, between the hospital and community settings, and support the implementation of clear and effective pathways.

Key actions

- **Where there is a clear need for the introduction, or enhancement of telecare, early referral should be made, well in advance of discharge.**
- **Referrers should have a knowledge of telecare and an awareness of referral processes, and liaise with TEC/telecare service as required.**
- **Referrals should contain the right level of detail to allow timely and appropriate installations; liaising with families and carers.**
- **The patient, and their family and carers, where appropriate, should be made fully aware of what telecare is, and that there is a charge.**
- **Telecare installers must be kept informed of discharge dates and notified of any changes, to prevent any installation delays.**

- **Lifestyle Monitoring can be considered to support assessment for care and support.**

Annex B: Driver Diagram


PRINCIPLE AIM: NO-ONE SHOULD STAY IN HOSPITAL LONGER THAN NECESSARY OR BE DELAYED IN THEIR DISCHARGE
AIMS
PRIMARY DRIVER
SECONDARY DRIVER
CHANGE IDEAS
Home is the default for all people leaving hospital.
Adopting a "Home First" approach, asking "why not home, why not now" at all points of a patient's journey.
Developing a range of intermediate care services
Assertive attitudes towards risk management
A quick turnaround from admission – avoid long lengths of stay.
Take a reabling approach. Help patients to stay active in hospital
Avoid unnecessary transfers in hospital/to community hospitals
✓ Discharge Lounges
✓ Back Home Boxes
✓ Prof to Prof Support
✓ End PJ Paralysis
All parties work to an agreed Planned Date of Discharge.
Patients, families and carers involvement in the discharge planning arrangements.
Discharge planning to be started early in the patient journey, preferably on admission.
Everyone working as one team, with one goal.
Early referral to social work
Dedicated social work staff dealing with hospital discharges.
Clear roles and responsibilities.
✓ Discharge Hubs
✓ Dedicated Discharge Managers
✓ Daily Huddles.
People are not assessed for their long-term support needs in an acute environment when at their most vulnerable.
Adopt "Discharge to Assess" ethos.
Commission a dedicated "Transition Team" (H2H) to support people for the first 72 hours.
Use of step-down beds in Intermediate Care, Community Hospitals and supported housing.
Involve the Third Sector
Signposting to alternative support
Strength based assessment and outcomes focused conversations
✓ Red Cross Hospital to Home
✓ "What Matters to You?"
Decisions are made and discharges occur across 7 days
Community services available to start/re-start across 7 days.
Availability of key decision makers.
Criterial led discharge
Timely access to equipment, Pharmacy & transport.
✓ Technology Enabled care
✓ Trusted assessors
There is good communication between professionals and with the patient, family and carer.
Patients, families and carers involvement in the discharge planning arrangements.
"Realistic conversations" – managing expectations & public perceptions.
Use agreed methods for transfer of referral detail.
Adopting robust choice protocols.
Single point of contact / access
Conversations about care homes are avoided
Put the person at the heart of decision making
✓ "What Matters to You?"
There is robust data and a series of indicators by which to measure performance and identify concerns.
Agreed single version of the truth
Importance of accurate coding
Indicators to measure progress
SMART Objectives
Training
Target: proportion of all discharges encountering a delay.
✓ "What Works Tool"
✓ Training videos