2. Act Now – plan for discharge early

Effective discharge planning supports the continuity of health and care for every individual. It streamlines the treatment received in hospital all the way through to post-discharge care provided in the community.

Early discharge planning can increase patient satisfaction, reduce hospital length of stay and reduce readmission to hospital. There is a wide variety of care available in the community, but it needs to be planned in advance, to ensure there is no gap in the provision of care. Information about the individual must flow seamlessly between care providers.

Act Now:

- ☐ Set an expected date of discharge (and to where) within 48 hours of admission;
- ☐ Involve the individual and their family in all decisions about discharge;
- ☐ Share, use and transfer all the information available about the individual to allow the team to get a better understanding of an individual's care needs and to enhance their experience;
- ☐ Be aware of the clinical criteria for discharge for each individual https://improvement.nhs.uk/resources/guide-developing-criteria-led-discharge/
- ☐ Ensure every day in hospital directly contributes towards an individual's discharge by adopting the Red2Green approach: https://improvement.nhs.uk/resources/red2green-improvement-tool/
- ☐ Get patients up, dressed and moving every day by embedding 'End PJ paralysis' in practice: http://www.endpjparalysis.com/;
- ☐ Make sure those individuals who are fit for discharge receive active reablement, incorporating a home first philosophy;
- ☐ For individuals returning to a care home with a Red Bag or folder, update and return these with the individual https://www.england.nhs.uk/urgent-emergency-care/hospital-to-home/red-bag/.

"Having vital information readily available in one eye-catching place saves time at each stage of the patient's care. It allows staff to make more informed decisions. It helps avoid all the phone calls that can happen with care home patients who may have a complex medical history; everything is there in the bag." Adult protection specialist nurse, Epsom & St Helier University Hospitals NHS Trust.

The Sutton "Red Bag" Scheme:

- Provides easily accessible, standardised information to health and social care professionals;
- Includes information on the person's general health, existing medications and the anticipatory care plan;
- Has identified improvements in streamlining transfers of care;
- Over a period of nine months in Sutton, 179 residents were tracked through the local hospital. The average length of stay with a bag was 13.4 days, down from 17.4 days without a bag.

Additional resources:

- https://improvement.nhs.uk/resources/guide-reducing-long-hospital-stays/
- https://www.local.gov.uk/our-support/our-improvement-offer/care-and-health-improvement/systems-resilience/overall-approach/early-discharge-planning
- https://improvement.nhs.uk/resources/ambulatory-emergency-care-guide-same-day-emergency-care-clinical-definition-patient-selection-and-metrics/
- https://www.england.nhs.uk/2018/06/red-bags-to-be-rolled-out-across-englands-care-homes-getting-patients-home-from-hospital-quicker/

Wherever possible, people should be supported to return home. This guide should be read in conjunction with "Act Now – getting people Home First"

Act Now – embed the Discharge to Assess Model

Assessment for longer-term care and support needs must be undertaken in the most appropriate setting and at the right time for the individual.

The Discharge to Assess (D2A) model is important, to ensure assessment for longer-term care and support needs is undertaken in the most appropriate setting and at the right time for the individual to improve discharge from hospital.

D2A models are appropriate when people are clinically ready for discharge and no longer require an acute hospital bed, but still require care services. It should work alongside time for recuperation, recovery and on-going rehabilitation.

Actions for health and care staff - the D2A model:

- ☐ **Make discharge home the first option;**
- ☐ Recognise that admission to hospital may be from different places across health and social care and be planned or unplanned;
- ☐ Provide continuity of care coordination from admission to discharge;
- ☐ Support the process to ensure required equipment is available by the discharge date;
- ☐ Identify appropriate opportunities for continuing healthcare assessments to be completed out of hospital;
- ☐ Provide an accurate, descriptive discharge summary;
- ☐ Work together as health and social care professionals to deliver trusted assessment to reduce delays to transfers of care.

Case study: Enhancing the Discharge to Assess model of care:

- District nursing leads worked collaboratively with other healthcare professionals to support the transformation of out of hospital care at the Newcastle Upon Tyne Hospital Foundation Trust;
- They developed a model for intermediate care, to provide care closer to home, or at home;
- During the pilot:
  - 89% were referred for step-down care;
  - Average length of stay reduced to 25 days, significantly below the expected 42 days;
  - Approximately 85% of patients were discharged back to their usual place of residence.
  - Only 4% of patients assessed closer to home were transferred to hospital for care.

https://www.england.nhs.uk/atlas_case_study/intermediate-care-pathway-enhancing-the-discharge-to-assess-model-of-care/

Additional resources:

- https://www.nhs.uk/NHSEngland/keogh-review/Documents/quick-guides/Quick-Guide-discharge-to-access.pdf
- https://www.local.gov.uk/our-support/our-improvement-offer/care-and-health-improvement/systems-resilience/overall-approach/discharge-to-assess

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