A guide for doctors

Why not home? Why not today?

Evidence shows it's much better for a patient's physical and mental wellbeing to leave hospital as soon as they are medically optimised for discharge.

This is why it's really important we do everything we can to enable our patients, particularly older people, to continue their recovery in their own home environment or, for those few who cannot go straight home from hospital, within a care location most suited to their needs.

You have an important part to play in making this happen. And there are a number of practical actions you can take to help get patients to the best place for them.

The evidence

There's lots of evidence to show that patients recover better at home once their treatment in hospital is complete. Patients who stay in hospital longer than is necessary may face issues including:

- **35% of 70-year-old patients experience functional decline** during hospital admission in comparison with their pre-illness baseline; for people over 90 this increases to 65%.[1]
- **48% of people over the age of 85** die within one year of hospital admission.[2]
- Exposure to the risk of **healthcare-associated infections.**

[1]Guide to Reducing Long Hospital Stays, June 2018.

[2]Imminence of death among hospital inpatients: Prevalent cohort study. David Clark, Matthew Armstrong, Ananda Allan, Fiona Graham, Andrew Carnon and Christopher Isles, 17 March 2014.

How you can make a difference

NHS England and NHS Improvement has worked with a number of partners to identify five key principles which can help ensure that patients are discharged in a safe, appropriate and timely way.

The principles relate to different stages of a patient's stay: some to the moment of admission, some to their time on a ward and some to the end of their stay.

1. **Plan for discharge from the start**
2. **Involve patients and their families in discharge decisions**
3. **Establish systems and processes for frail people**
4. **Embed multidisciplinary team reviews**
5. **Encourage a supported home first approach**

Underneath each key principle are specific actions that you can take as a doctor.

By following these actions and thinking **"Why not home? Why not today?"** every day, we can reduce length of stays and get patients to the best place for their recovery.

1. Plan for discharge from the start

- Assess your patient's cognitive, functional and social status before and on admission.
- Ensure all patients have a clearly documented plan in their medical notes that includes an Expected Date of Discharge. It should also include Clinical Criteria for Discharge which describe both functional and physiological parameters (considering a patient's functional needs including social care and living arrangements).
- Participate in early daily senior reviews.
- Think "Why not home? Why not today?" every day. If the patient can't go home today, proactively identify what is required to support discharge and within what timescale.
- Consider criteria-led discharge.

2. Involve patients and their families in discharge decisions

- Ask all patients (or their family members or carers for cognitively impaired people) the four questions listed below to check they know their plan:
  1. Do I know what is wrong with me or what is being excluded?
  2. What is going to happen now, later today, and tomorrow to get me sorted out?
  3. What do I need to achieve to get home?
  4. If my recovery is ideal and there is no unnecessary waiting, when should I expect to go home?
- When discussing discharge decisions ensure you have asked patients what matters to them and explain the risk of an unnecessary prolonged hospital stay.
- Ask why patients are still in bed and include the need for patient mobility in their medical notes.

3. Establish systems and processes for frail people

- Ensure frail people are identified as early as possible using a validated tool such as the Clinical Frailty Scale (CFS) and make sure there's an effective frailty process that delivers early comprehensive geriatric assessment.
- Ensure people with frailty are assessed by an appropriate professional before admission.
- Engage with a single assessment process and patient record which is completed by the whole team.

4. Embed multidisciplinary team reviews

- Ensure the patient's functional and physiological status is discussed at all MDT reviews including board and ward rounds.
- Participate in discussions regarding all possible discharge options and discuss these with patients and their families or carers after the meeting.
- Ensure relevant improvement measures are readily accessible for front line teams so they can see how they're doing. Encourage teams to use information to make decisions.

5. Encourage a supported home first approach

- Think #homefirst and consider support at home or with intermediate care.
- Encourage colleagues to assess patients' needs in a non-acute setting (preferably their normal place of residence) rather than in an acute hospital setting.
- If discharge to assess at home is not possible, explore alternative community options.