A guide for therapists

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 therapist.

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

- Increase therapy input in Emergency Departments and acute medical assessment units so patients can be immediately assessed, and a comprehensive geriatric assessment undertaken for people with frailty.
- Fully understand the patient's cognitive, functional and social status before and on admission.
- Ask "Why not home? Why not today?" every day. View patients' time as the most important currency in healthcare.
- Consider criteria-led discharge.

2. Involve patients and their families in discharge decisions

- Explain to patients the risks of a long-term hospital stay versus going back to their normal place of residence or a non-acute hospital setting.
- Ask the patient what matters to them and, where possible, gather information from paramedics, carers and family too. Make sure this information stays with the patient throughout their hospital journey.
- Encourage all members of the multidisciplinary team to get patients up, dressed and moving. Think #EndPJparalysis.

3. Establish systems and processes for frail people

- Ensure people with frailty are identified as early as possible and there's an effective frailty process in place that delivers an early holistic assessment.
- Ensure people with frailty are assessed by an appropriate professional before admission.

4. Embed multidisciplinary team reviews

- Describe patient needs, rather than prescribing definitive solutions for long-term care. Avoid the use of the term "back to baseline".
- Contribute to daily and ward rounds and other multidisciplinary team reviews.
- Encourage multidisciplinary team members to review each of the following areas every day: physical health status, mental health status, functional ability (mobility, personal care and continence), nutritional and hydration status and ongoing support required for discharge. Proactively share this information with all members of the multidisciplinary team.
- Encourage a weekly review of all long stay patients that involves multidisciplinary team members visiting wards to help unblock constraints. Implement effective escalation processes where there are unnecessary patient waiting times. (See page 29 of Reducing Long Hospital Stays Guide for more information.)
- Ensure relevant improvement measures are readily accessible for frontline 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.
- 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.