A guide for social care professionals

NHS

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.**

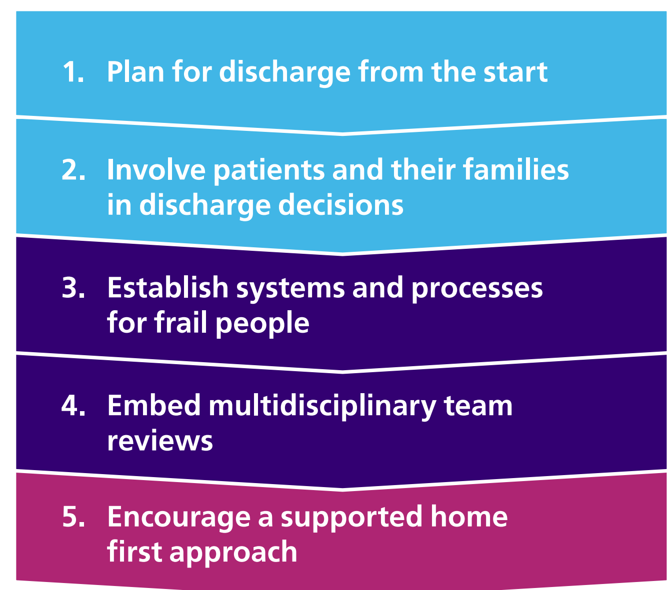
[1]Guide to Reducing Long Hospital Stays, June 2018.

[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.



Underneath each key principle are specific actions that you can take as a social care professional.

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.

where best next?

1. Plan for discharge from the start

- Ensure your team/local authority has practical arrangements in place to help identify residents who are admitted to hospital.
- Work with the multidisciplinary teams (MDT) to ensure that the social care components (where appropriate) of a patient's discharge plan align with the expected date of discharge (EDD).

2. Involve patients and their families in discharge decisions

- Make sure the patient has been asked what matters to them and positively challenge health professionals who may wish to make decisions for people.
- As part of discussions with the MDT, be prepared to advocate the risks the patient is willing to take to achieve a discharge home.
- Ask all patients (or family members/carers for cognitively impaired people) the four questions listed below so 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?

3. Establish systems and processes for frail people

- Ensure that frailty care pathways are established from primary care into acute care and from acute care back to primary care.
- Take steps with partners to ensure that people with frailty who have social care needs have easy access to care navigation and/or care management services, in order to support smooth transitions between the different kinds of care that will be needed.

4. Embed multidisciplinary team reviews

- Ensure social care professionals participate in MDT discussions about a patient's care and discharge plans.
- To support this, seek to agree a 'trusted assessment' approach between members of the MDT in order to achieve maximum responsiveness and to minimise delay for the patient.

5. Encourage a supported home first approach

- Challenge any proposed decisions about a person's long-term care being made in hospital.
- Work with partners to implement a "discharge to assess" model, where the majority of patients are assessed in their own home.
- Embed a culture which advocates that "patients are citizens who happen to need hospital and who should be able to expect to return to their own home once they no longer need hospital treatment".