# Transforming Urgent and Unscheduled Care

# Optimising Flow

# Discharge without Delay

## A Best Practice Discussion Paper

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## Contents

## 1. Background

Bringing together expertise across the whole system, and taking a collaborative approach to amalgamating good practice is at the centre of the Scottish Government's approach to delivering Unscheduled Care in Scotland, supported by the new National Centre for Sustainable Delivery (CfSD).

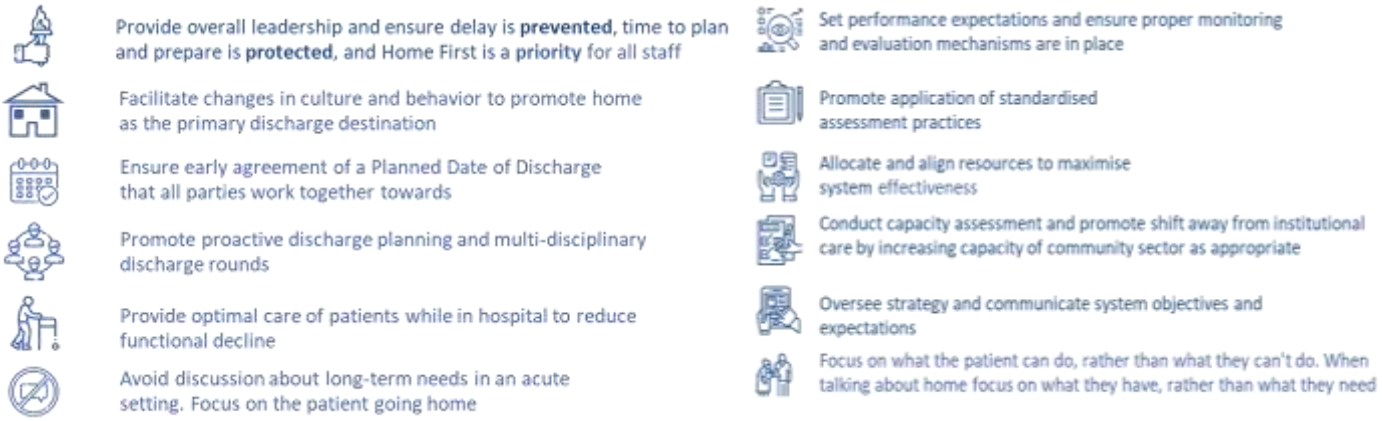
This document is the outcome of a joint piece of work sponsored by the Scottish Government's Unscheduled Care Programme and 'Home First' Teams, engaging with experts from across the whole system, to find out what works well and puts patients at the heart of planning and preparing for discharge.

To establish what works well, it is important to first understand what doesn't work so well. In discussions, the expert group noted that variation in approach occurs across all areas of discharge planning, the journey from admission to discharge whether Social Care support is required or not, is often longer than clinically necessary. As complexity increases, so too it feels, does the risk of delay. The journey from being an acute inpatient to going home or to a homely setting, can appear disjointed. In many cases planning is not joined up, early enough or undertaken with engagement from all key stakeholders. There are many things which we collectively do, and don't do, which causes delay for patients and impacts on outcomes.

This of course offers us opportunities to make things better, to ensure that our systems and processes don't add to, or inadvertently cause delay. This paper, therefore, aims to define best-practice, centred around preventing delay in all patient journeys and ensuring patients stay in hospital only as long as is clinically and functionally necessary.

A Short Life Working Group, established in February 2021, was led and sponsored by the Scottish Government (SG). The over-arching group was chaired by Julie White, Chief Operating Officer and Chief Officer, NHS Dumfries and Galloway. This group engaged expert clinical and operational leaders across the system to develop discussion paper by exploring and defining best practice. ***The outcome of this work was a set of high level recommendations for Health and Social Care Systems Leaders.***

This approach benefits from Ministerial sponsorship to take forward a joint programme of transformation in a truly collaborative, cross-dimensional way.



## 2. Introduction

Good discharge planning is an essential element of acute hospital patient flow and community service capacity. The mismatch of demand and capacity an almost constant pressure for the acute hospital sites and Health and Social Care Partnerships. The planning of discharges, and keeping to the plan, is therefore a vital element of flow. Optimising flow, by preventing delay, is best for the patient/service user, the staff and of course the system itself.

This document attempts to bring together the key parts of good discharge planning, as demonstrated by Health and Social Care staff across Scotland.

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 identification of discharge requirements, early ordering of the things essential for discharge, early referrals, early involvement of the multidisciplinary team, including social care expertise, early planning, early decisions, all essential elements of a timely journey through hospital. This involvement can seldom be too early and needs 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 date. This date may be set by ward staff, may not be visible to the wider MDT and does not always reflect a patient’s recovery rate, making preparation for discharge difficult. This presents a significant opportunity to shift the way we make discharge arrangements.

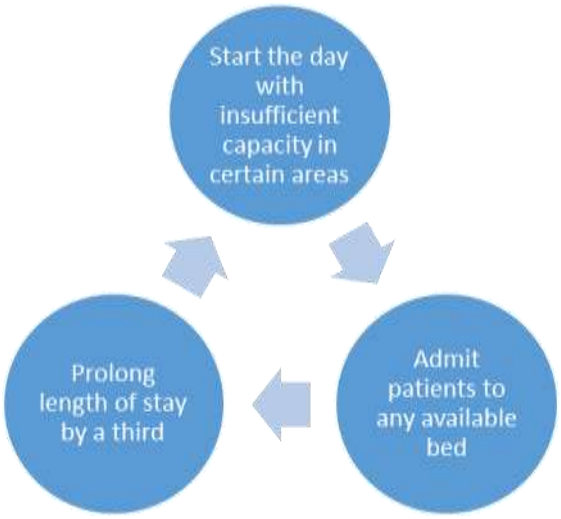
That is why we are recommending a change to how teams plan. We want to shift from EDD to PDD – Planned Date of Discharge. This is not just a change of terminology, although that in itself is important to drive behaviour from an “estimation” to a “plan”, but rather a cultural shift towards engaging everyone in hospital discharge from admission. This means including the patient themselves, family and carers where necessary, in working towards a jointly agreed date.

We mention patients, family and carers 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.

***Discharging without delay for ALL patients leads to better outcomes; for the patient, the system and the staff who work in it.***

### Patients without ongoing health or social care needs

Late decision making and planning for patients with ‘simple’ discharge requirements, often on the day of discharge, has a significant and far-reaching impact on ‘patient flow’ and the resulting patient, and staff, experience of Unscheduled Care. For example, across many acute sites, discharges reach a peak many hours after the pattern of admissions has peaked. Balancing demand and capacity is impossible in this context, and patients are often admitted to beds which may not be best for their needs. Conservative estimates suggest ‘Boarding’ or ‘outlying’ extends length of stay by up to a third. This vicious cycle (visualised below) can be seen in acute sites across the country. As pressure (and front door queues) build, discharge behaviours can become even more reactive. For some patients this is likely to lead to a re-admission.




It's a better outcome for the patient if they are able to go home as soon as they are clinically fit. It's a better outcome for the system if discharges are in the morning, and demand is better aligned with capacity.

## Patients with ongoing Health and Social Care needs

It often feels like as complexity increases, so too does the likelihood of delay. Changing how we plan does not mean discharging more quickly, but ensuring good planning and preparation ***prevents*** delay. For those with more complex discharge needs, the PDD must be realistic and reflect recovery from an acute episode, with ongoing requirements assessed in a more appropriate and conducive environment. Realism should extend, where necessary, 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 may lead to readmission.

Delayed discharge is a whole system problem that needs a whole system solution. Delays come about when parts of the system are fractured and disconnected. 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 be synchronised with each other. The "journey" for the individual patient needs to be a seamless transition, and not a series of handoffs. We discuss different roles and responsibilities later in this document and surface the interplay.

Good discharge planning should result in better patient outcomes, fewer delayed discharges, shorter lengths of stay and reduced hospital readmissions. Early actions and whole-system planning should enable an assertive and proactive approach to managing risk. Equally, reducing length of stay requires admission to the right ward, early involvement of the multi-disciplinary team, consistency in the use of PDD and clear clinical criteria for discharge.

Using a PDD approach 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 effective strategic planning of services to support discharge, particularly in commissioning the support of the third sector.

***For many older people, disjointed or silo planning combines to cause delay in accessing the services required to support discharge. This often leads to poor patient experience, adverse clinical outcomes, lengthy delay in discharge and can ultimately prevent a return to home.***

When talking about good whole-system discharge planning as a critical tool in the operational management of patient flow, it is interesting to note 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 far less pressure on hospital beds.

In summary, this paper identifies the key themes of good discharge planning across all patient pathways, taking account of the lessons learned exercise that was carried out in July 2020, which looked at the changes made in March-June 2020 which saw delayed discharges reduce by over 60%.

**The Discharge without Delay approach aims to reduce delay in every patient journey by:**

- **Prioritising planning and reducing the risk of inadvertently causing delay using a 'pathways based planning' approach to support morning/daylight discharge**
- **Whole-system planning and preparation for discharge**
- **Adopting 'home first' as an ethos, 'discharging to assess' as a default**

## 3. Approach

Membership of the expert group is located in **Annex A.**

The group initially explored Acute Discharge planning and 'Home First' as separate pieces of work, however rapidly agreed that the pathway is inextricably linked - but often did not feel like that. Therefore, a decision was made to prepare guidance which supported a united approach to discharge planning and preparation across all patient pathways.

In addition, the scope took in single point of access, rapid response models, intermediate care/community hospitals, staff profile/staff mix, whole system approach, outcomes data, communication and enablers, and agreed good practice examples in each of these areas. 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 represented 'best practice' and should be adopted consistently. These include the use 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 adopt 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 some contrasting evidence about whether it is better to have dedicated social work teams based in an acute hospital or have community teams in-reaching.

## 4. Who is this document for?

In wrapping an 'improvement approach' around the high level recommendations, NHS Boards and Health and Social Care Partnerships should undertake a self-assessment of

what is currently in place, and take action to close any 'gaps' identified. This 'gap analysis' should engage key stakeholders in taking a whole system approach to developing a consistent and effective discharge planning process, ensuring the high impact changes laid out in this document are adopted.

## 5. Purpose of this Guidance

The purpose of this guidance is to:

- Support hospitals to improve the patient and staff experience of unscheduled care by reducing length of stay, releasing capacity and improving 'in day' flow
- Provide a 'once for Scotland' view of best practice in relation to preventing delay through robust whole system discharge planning through the acute environment, and the adoption of 'Home First'

## 6. Discharge Planning

**Reducing delay across all patient pathways is an essential element of reducing length of stay and releasing unnecessarily consumed capacity.**

**A good discharge is one that is planned, centred around the patient, and free from delay.** Ensuring systems and processes are set up, and time is dedicated and protected, to support teams to plan and prepare for discharge from admission is critical. Making sure that the timely identification and completion of the tasks required for discharge is viewed as an essential part of the care we deliver to our patients is essential. Organisational culture should be aligned with systems and processes to prevent delay. Harm is caused by delaying discharge and the implications for all are significant.

Preventing delay on the day of discharge directly supports getting patients to the right bed at the right time, first time.

For some time now, the 6 Essential Actions for Improving Unscheduled Care National Programme has been supporting Boards across Scotland to develop consistent discharge planning processes for some time through the adoption of the 'Daily Dynamic Discharge' approach.

The DDD approach dictates that rigour and discipline is required to prioritise and protect time to plan for discharge, focusing on the few key interventions to prevent delay, and deliver discharge earlier in the day. The group agreed that this work was highly impactful and is largely still used (to varying degrees) with the terminology widely known. There is an opportunity to refresh the model and extend the key principles of EARLY and CONSISTENT planning to decision making and overall journeys across more complex pathways.

**The Pathways Planning Model (located at Annex C), builds on the Daily Dynamic Discharge approach, puts patients at the centre of discharge plans and ensures that the fundamental elements of good operational management of patient flow are consistent in all inpatient areas, for all pathways**.

The model suggests there are 4 pathways which each require good, early, discharge planning but as complexity increases, so does the requirement to widen engagement in decision-making and planning.

1. Simple Discharge – no ongoing health and social care needs
2. Moderately Complex Discharge – known to Social Care, may need some input
3. Complex Discharge – likely to require significant Social Care input
4. End of Life – should follow a 'fast track' pathway

All pathways require early decision-making, identification of, and completion of the tasks required for discharge, in advance of the PDD. These are fundamental elements of good patient experience and hospital flow in an acute setting. This means that they should happen for every patient, every time.

**In inpatient wards,** this means:

### Overall

- Setting an MDT agreed Planned Date of Discharge
- Reviewing this PDD daily with the MDT with the parameters for discharge defined and criteria led discharge in place where appropriate
- Ensure any equipment, technology, changes or preparations at home; are all organised well ahead of the PDD Involving patient/family/carer in planning from admission
- Providing patient information on admission

### Each Day (7 days a week)

- 2 x daily discharge planning meetings
    - AM huddle finalising any last minute tasks and setting the order of the ward round
    - PM huddle – post ward round, planning of tasks and getting ahead of TOMORROW'S discharges TODAY
- Book transport day before
- Use of Criteria-led discharge
- Create the discharge documentation/IDL (immediate discharge letter) the day before
- Order discharge drugs/TTO/TTAs (to take out/away) the day before
- Golden Hour ordered Ward Rounds (see urgent sick patients, then those for discharge then all others)

### On the Day of Discharge

- Use of the discharge lounge as default (discharge lounge staff providing breakfast clubs where possible)
- Sitting out
- Early collection from ward
- Pre-noon discharge as default

**At a Hospital level,** this means:

To complement effective planning, responsive systems and processes to support the operational management of patient flow such as effective huddles, to which delay can be

escalated for a resolution, monitoring/management of pre-noon performance will be required to equate improved planning to improved 'in day' flow.

Monitoring the reasons why pre-noon discharge may have been prevented should be an indicator of patient experience as well as overall performance. This provides an opportunity to test the impact of enhancing services which support discharge; such as dedicated prescribers, ward-based or community pharmacy, HALO (Hospital Ambulance Liaison Officers), 'bed busters' etc. Many Unscheduled Care Programme Boards direct resource and funding for this purpose based on analysis of pre-noon discharge performance. This may sit alongside other improvement tools such as ward-based metrics (LOS, pre-noon discharge, weekend discharge) and Day of Care Audits (DOCA). Understanding the data is critical to ensure system learning and action planning.

**For the more complex discharge pathways 2 and 3, there is a need to firmly join the thread across acute and community teams. Early referral and engagement of the wider multi-disciplinary team * which should include social work / home care in planning for those with more complex needs is critical.**

This tool supports Boards to ensure their approach is consistent and effective across ALL patient pathways.

### 6.1 Key actions

- Teams across the health and social care landscape should assess their current systems and processes and identify gaps across all pathways, in the acute environment for 'simple' discharges, and for more complex discharges from a whole-system planning perspective - as part of the 'self-assessment' tool'
- A 'lead' person/s to take forward changes in acute and community settings, both cultural/behavioural and from a system and process perspective should be identified
- Continually monitor the effectiveness of these changes through performance data at a ward AND system level (LOS, AM discharge rates, waits for bed in ED)

## 7. Home First

Patient journeys in pathways 2 and 3 are more complex and may, as a result, be at greater risk of delay while waiting to move to home or the next appropriate area of care. 'Home First' should be considered an alternative. This will require a change in the parameters for discharge, as well as to how planning is approached.


The principles behind a successful Home First approach are now fairly well established. These are largely inter-changeable with "discharge to assess" or good discharge planning, but also bring in admission avoidance, accessing the right acute specialty where admission is required and quick turnaround for those admitted with only

essential assessments undertaken whilst in hospital.

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.

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 length of stay prior to being ready for discharge. 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”. Prolonged stays in hospital are unlikely to improve physical or mental capabilities and recovery may be better at home. Hospital stays should ensure that a patient is clinically well, and prepare for discharge home at the optimal time. Missing that moment can lead to a deterioration, a prolonged length of stay and a much poorer outcome.

A separate workstream looking at how community hospitals are used has demonstrated that most patients entered via an acute hospital and that they can go on to experience lengthy further periods of inpatient care. It is possible that some of these patients could have gone directly home and received further rehabilitation in their own home, re-engaging much earlier with family and their community.

There is a pressing need to rebalance the approach to risk and consider ‘realistic care’. We know that social care support can be over-prescribed when assessed in an acute setting when patients are in the acute phase of an episode of care. Often the maximum package is sought with professionals endeavouring to secure a safe discharge. Often professionals, with the best intentions, seek the gold standard for people coming out of hospital, invariably delaying discharge if it is not available.

Increasing awareness of the potential harm this can do is critical. Patients could, instead, return home with “enough” support, rather than waiting for the gold standard. Citizens often manage at home waiting on packages of care that are often greater than those delayed 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 encourages all health and care professionals to ask the questions “why not home, why not now?” at every stage of the hospital journey, 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 professionals may prescribe more for their patients that they would for themselves. The same could be said about assessments for community services. Where possible, discussions around care home placement should not happen in hospital. This ensures the focus remains on returning home for further assessment. The

earlier the communication with patient and their family around the elements of the discharge plan, the better.

Very few people want to go to a care home or would choose that option for themselves, and those who do, should be placed from the community rather than hospital following an episode of acute care. Everybody should be offered the opportunity to recover in their own home or in a homely setting, and transfers directly from acute hospital care to long-term residential care should be avoided wherever possible.

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 expert group unanimously agreed that an acute setting is the worst place to assess someone, yet data tells us up to a quarter of all delays in hospital are awaiting assessment.

Moving to a 'discharge to assess' system where people are routinely discharged home, without delay, would allow for assessment in their normal environment, where they will be more confident and comfortable.

There will of course be cases where someone is unable to go straight home, and when they may need a period of rehabilitation, with time to recover, 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 are clear criteria for using them and that each episode is time limited (while allowing some flexibility to realise every opportunity to discharge someone 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 has enough data to be able to predict how many older people will need intensive support to get them home from hospital, and to create a multidisciplinary team solely for this purpose.

Others with lesser needs could be cared for over the short-term by 'reablement' teams and/or voluntary organisations. 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*[1]", illustrates 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:


Many Partnerships told us they are embedding a Home First ethos. But how many continue to admit as the default for the frail older person, and then pass people round the hospital system from specialty to specialty? How many assess someone's long-term needs in an acute hospital? How many transfer directly from an acute hospital to long term residential care?

[1] You can read the Home to the Unknown Report at https://www.redcross.org.uk/about-us/what-we-do/we-speak-up-for-change/more-support-when-leaving-hospital/getting-hospital-discharge-right

How many people continue accrue delay in their discharge? And in answering those, can we really say that we operate with a consistent Home First ethos?

### 7.1 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.

## 8. 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 be a component of the flow navigation centre, so that staff a can seek alternatives to hospital admission. From the back door, ward staff should have a clear point of referral. This referral, for ongoing support in the community, should be completed 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 may be no requirement for referral. Otherwise though they cannot be too early, noting that in many cases currently they are far too late. Social Work are often expected to make immediate arrangements, even 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 our initial stocktake if referrals could be too early? The near unanimous response was that no, they couldn’t be, and the earlier the better so that at least they had some warning of what might be needed ‘further 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 to refer.

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 default to 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.

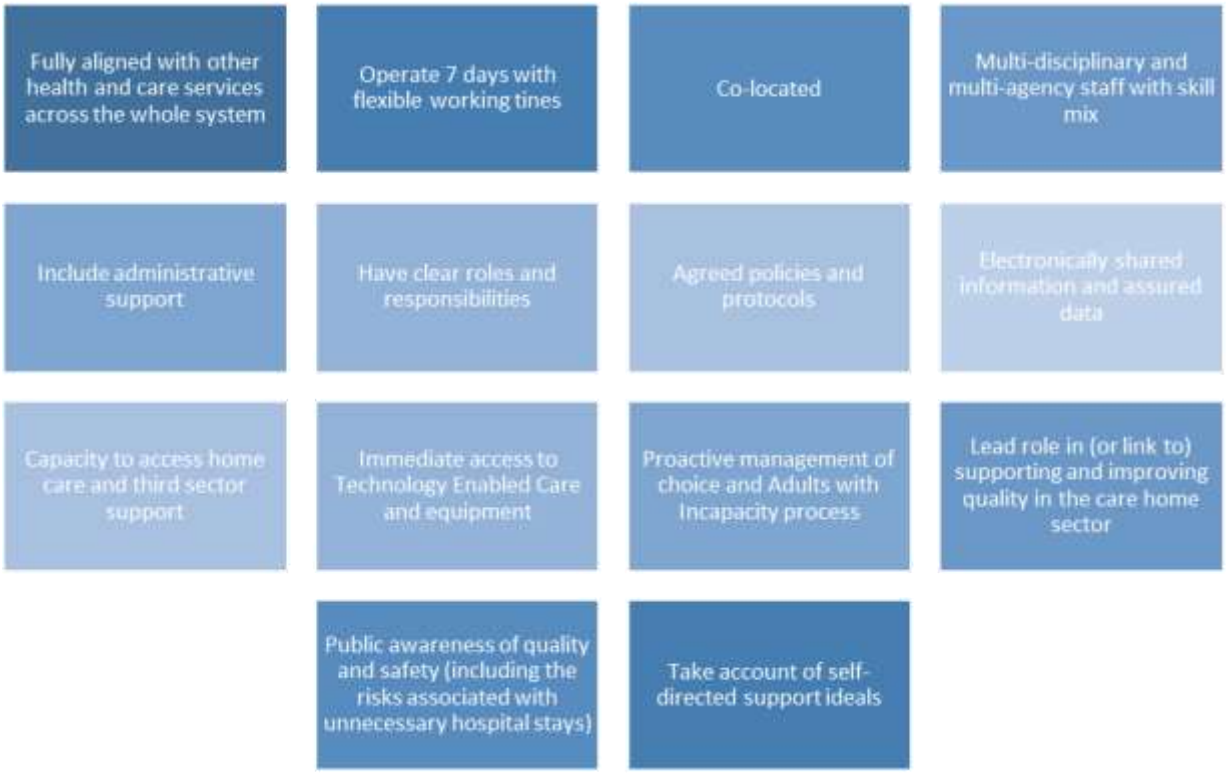
There is no consistent method for making referrals. In some cases, this is done verbally or by email, while many are made via a Patient Management System. The fact that patient management systems and social care databases are not linked remains an inhibitor. While consistency of approach would be beneficial 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 good quality and standardised to allow the right care to be sought. This is also 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 services, such as those provide by third sector organisations, community services, 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 over-arching principle is that it must be integrated, although 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 the input of those who have expertise and consistent involvement in discharging patients.

There are also clear benefits to 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 get actively involved in non-routine discharges. Routine cases should be the responsibility of ward staff to discharge without delay.

Good examples describe a managed service network as an integrated team focussed on discharge planning. Ideally, ward staff should have good knowledge of social work eligibility criteria which may promote allocating support only to those deemed to have critical or substantial needs. 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 good 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 in 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 and balancing of risks. They should be able to span traditional organisational boundaries and ensure there are no impediments to

timely discharge home. In addition, they should contribute to longer-term sustainability ensuring that delayed discharge is seen as a collective responsibility rather than that of an individual.

What has previously been highlighted as poor practice is dependency on either the Hub or Discharge Manager to solve 'complex cases', de-skilling others and adding delay into a patient's journey. Hospital staff must retain ownership of communicating and having potentially difficult conversations around the appropriateness of a continuing inpatient stay, and the need for imminent discharge where appropriate.

### 8.1 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.

## 9. 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 (H@H). 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.

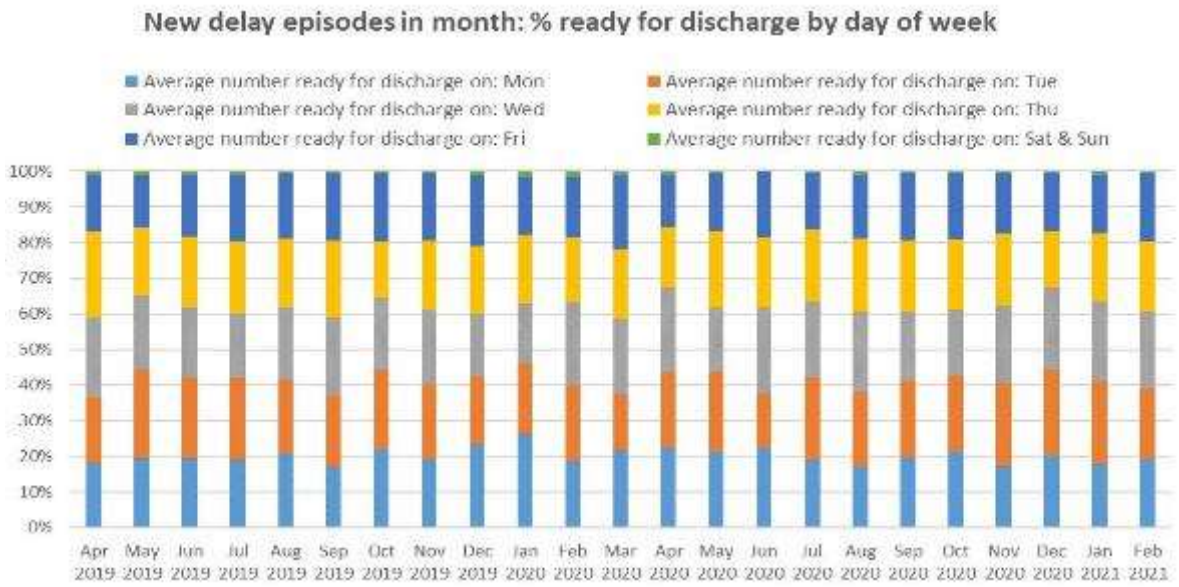
If the voluntary sector has been mobilised and more informal care and support has been provided, the requirement for statutory services may be reduced. There is a need to harness the general goodwill to fellow citizens, in terms of the informal care and support delivered by wider networks of family, 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 widely observed. 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

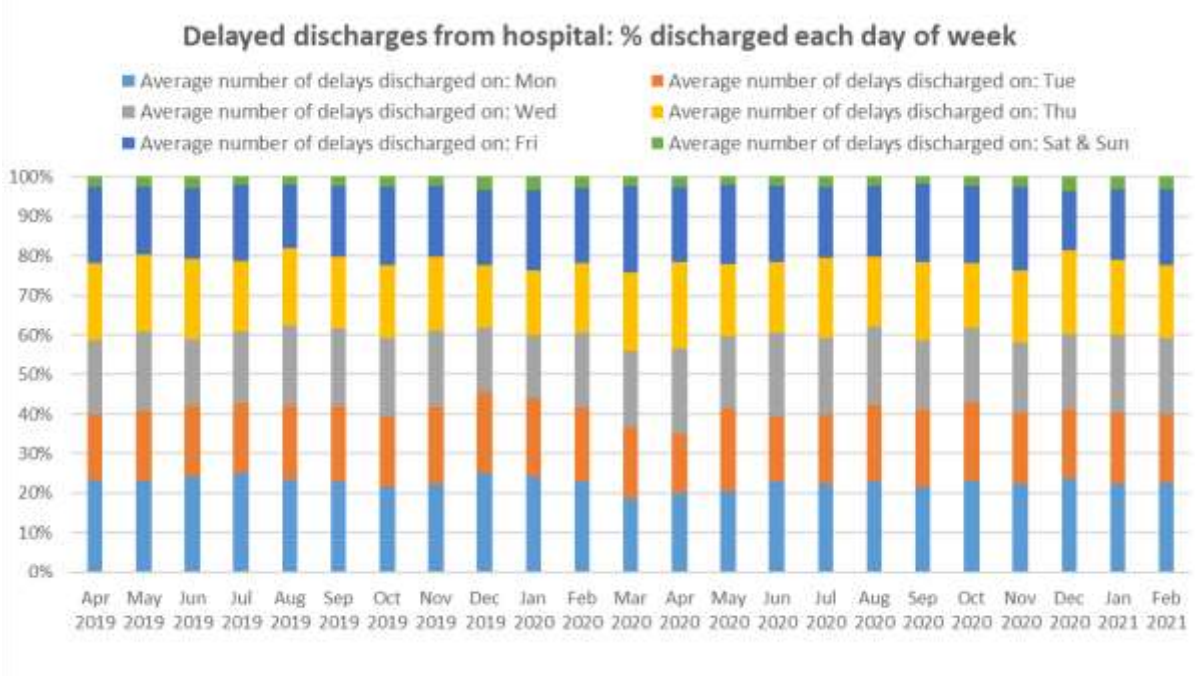
homes that were unsuitable or inappropriate for their recovery and their changed or changing needs. This ranged from struggling with a single step up to a front door, to feeling unable to get upstairs to the toilet.

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 a negative impact on longer-term recovery and increases the likelihood of re-admission.

Seven-day working is also necessary for providing a rapid response in preventing delay in discharge. While social care are often unable to offer seven day working as most NHS organisations are, data has shown the absence of weekend senior clinical decision making within hospitals being a major factor in delay.




In some tests of change shared with the expert group, social work teams have been stood up to take referrals over the weekend but the service was not well used. There are likely many reasons for this, but it is noted that, even with weekend referrals, there is a reluctance of private sector providers to accept new clients over the weekend, and a preference by care homes and care at home rotas for discharge 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 needs all parts of the system to be geared up to do their part each day.

### 9.1 Key actions

- A dedicated 'Hospital to Home' function could be established in all areas, which includes third sector and or local community support.
- Discharges and discharge decisions should be made across seven days, the use of Criteria Led Discharge supports discharging over the weekend when clear parameters for discharge are set and others in the multi-disciplinary team can finalise the discharge.
- 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.

## 10. 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 explored 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 operating model of community hospitals varied across the country, and that there is 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 future 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 could be visited in the future.

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.

This document includes a number of recommendations and Key Actions for HSCPs to help make optimum use of their community hospitals. Further toolkits and guidance will also be developed.

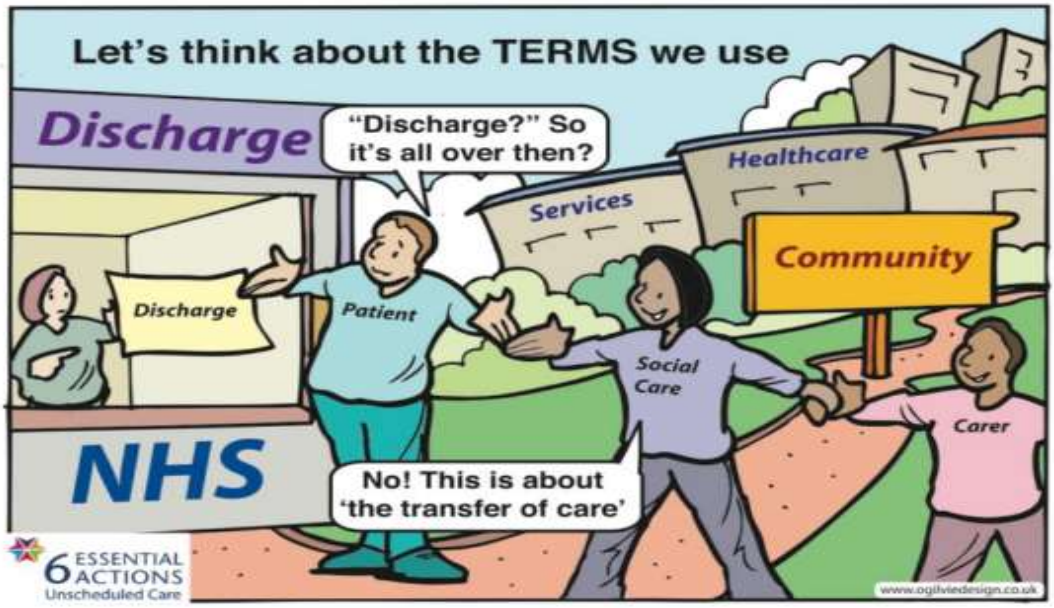
Recommendations and Key Actions can be found in the Community Hospital and Intermediate Care Report [add link].

### 10.1 Staff Profile and Staff Mix

Most hospital-based teams could be described as multi-disciplinary with a necessary mix of staff and disciplines. This 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 co-ordinating 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.

Engaging and including the patient and their family and carers from the offset is key. Family and friends often 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 and communication between teams stemmed from the clinical handoff, with the detail of the patient 'needs' breaking down between ward staff and the wider team. 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 from admission to hospital. 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:

| |
|---|
| |
| • Should be fully engaged in planning for discharge from the earliest stage<br>• Should be given clear information, advice and support about the discharge process, including access to independent advocacy services<br>• Support timely discharge and prevent unnecessary barriers and delays |
| |
| • Should be consistent in the messaging that patients should go home and that remaining in hospital is not best for the patient<br>• Ensure the involvement of family and carers in discussions about ongoing care needs<br>• Contribute to discussions around the Planned Date of Discharge<br>• Work on discharge arrangements towards the planned discharge date |
| |
| • Assess when someone is likely to reach the end of their treatment plan and be clinically ready for discharge (as part of MDT discussions)<br>• 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 mitigation and management<br>• Ensure timely creation of documents required for Discharge such as the Immediate Discharge Letter (IDL)<br>• Ensure prompt arrangement of any discharge medicines in advance of the discharge date and facilitate discharge at the optimal point in the day (morning discharges are widely stated as positive for the patient and the system)<br>• Ensure that all infection prevention and control measures are followed per Health Protection Scotland (HPS) guidance |
| |
| • Ensure effective and inclusive engagement with the patient, family and carers throughout the discharge planning process<br>• Senior Charge Nurses often use their expertise in discharge planning in line with Home First principles and practice<br>• Therapists often ensure discharge planning starts as early in the process as possible and have great intelligence around the patients functional capabilities and living arrangements<br>• Liaise with social work staff to ensure early identification of people who might need on-going support<br>• Provide information and advice to ensure people have realistic expectations of care<br>• Keep patients as active and stimulated as possible to avoid deconditioning |
| |
| • Ensure discharge planning starts as early in the process as possible<br>• Support family and carers through the process<br>• Commission provision of on-going community support where required<br>• Ensure a reablement approach is taken and avoid unnecessary delivery of care<br>• Lead the completion of assessment of ongoing need and supports, post-discharge from hospital |

Behaving as a team, united in supporting the patient to access what they need, when they need it means that some cross boundary working is required, many therapy teams behave as 'trusted assessors' following clear guidelines and supporting a holistic view of the patient's needs. 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 should be provided by social care professionals. There are many examples of integration bringing teams together which have blurred the boundaries between roles with many examples of good practice. There are also examples of misguided practice such as this, heard at a daily huddle. Discussion took place around 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 a cultural shift will be necessary to do things differently. As such, hospitals need to ensure all staff, including clinicians, nursing, AHPs and social care workers, understand and 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.

### 10.1.1 Clinical Staff

Clinicians in the hospital and community should be engaged in developing the approach 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 is likely to rest 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.

### 10.1.2 Nurses

Nurses are 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 questions and reassure them of the 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.

### 10.1.3 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 discharge planning and the application of Home First principles. 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.

### 10.1.4 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.

### 10.1.5 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. Active monitoring of patients while they are recovering and receiving care at home ensures timely recovery and prevents unnecessary readmission to hospital.

### 10.1.6 Clinical Leadership

Leadership 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.

### 10.2 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 the preferred option. Where this is not possible, regular 'virtual' meetings across teams should be the ideal.

## 11. 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 are discussed and managed as a number, and efforts are focused on reducing that number to ease pressure on other parts of the system. A previous Health Minister stated "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 is the ideal future state.

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 what is needed to get someone well 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.

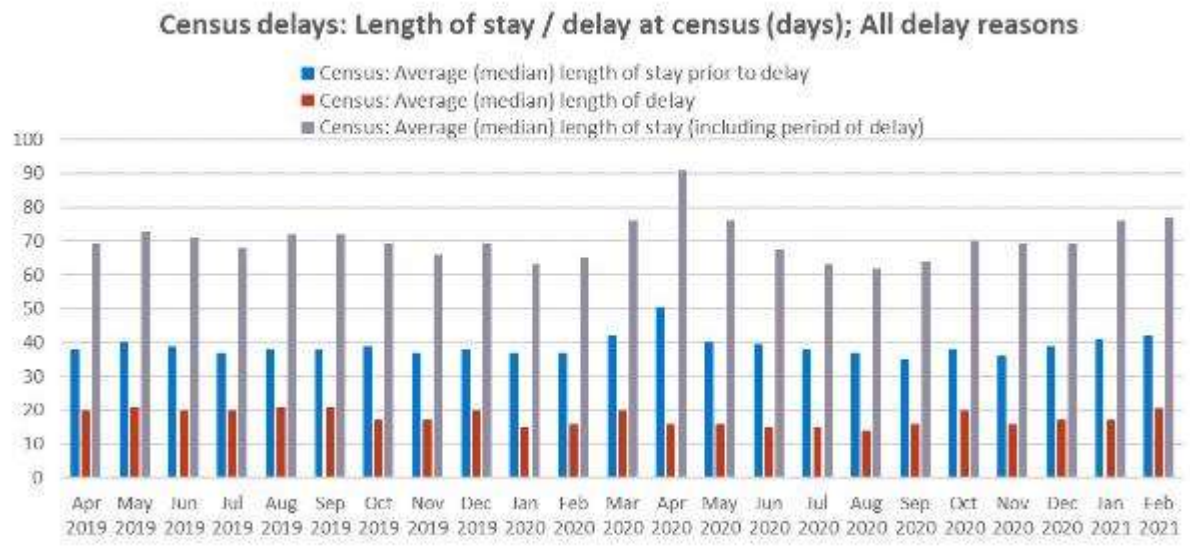
Most partnerships have unscheduled care boards or working groups, discharge planning as a part of the optimal patient pathway and improving experience and outcomes, should be a key action of these groups and this should be reflected in local action plans.

Evidence suggests it is advantageous if Partnerships 'track' their patients across their journey, knowing when they have been admitted and proactively planning for discharge. It is important that inpatient settings take an active role in optimal discharging. We know that people will lose muscle capacity and general life-skills the longer they are in a bed.

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 (Scottish Care of Older People) 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 may see several doctors before they are seen by a geriatrician, only to confirm that frailty is the primary condition. Healthcare Improvement Scotland's 'Frailty at the Front Door' collaborative work has already shown results in reducing lengths of stay.

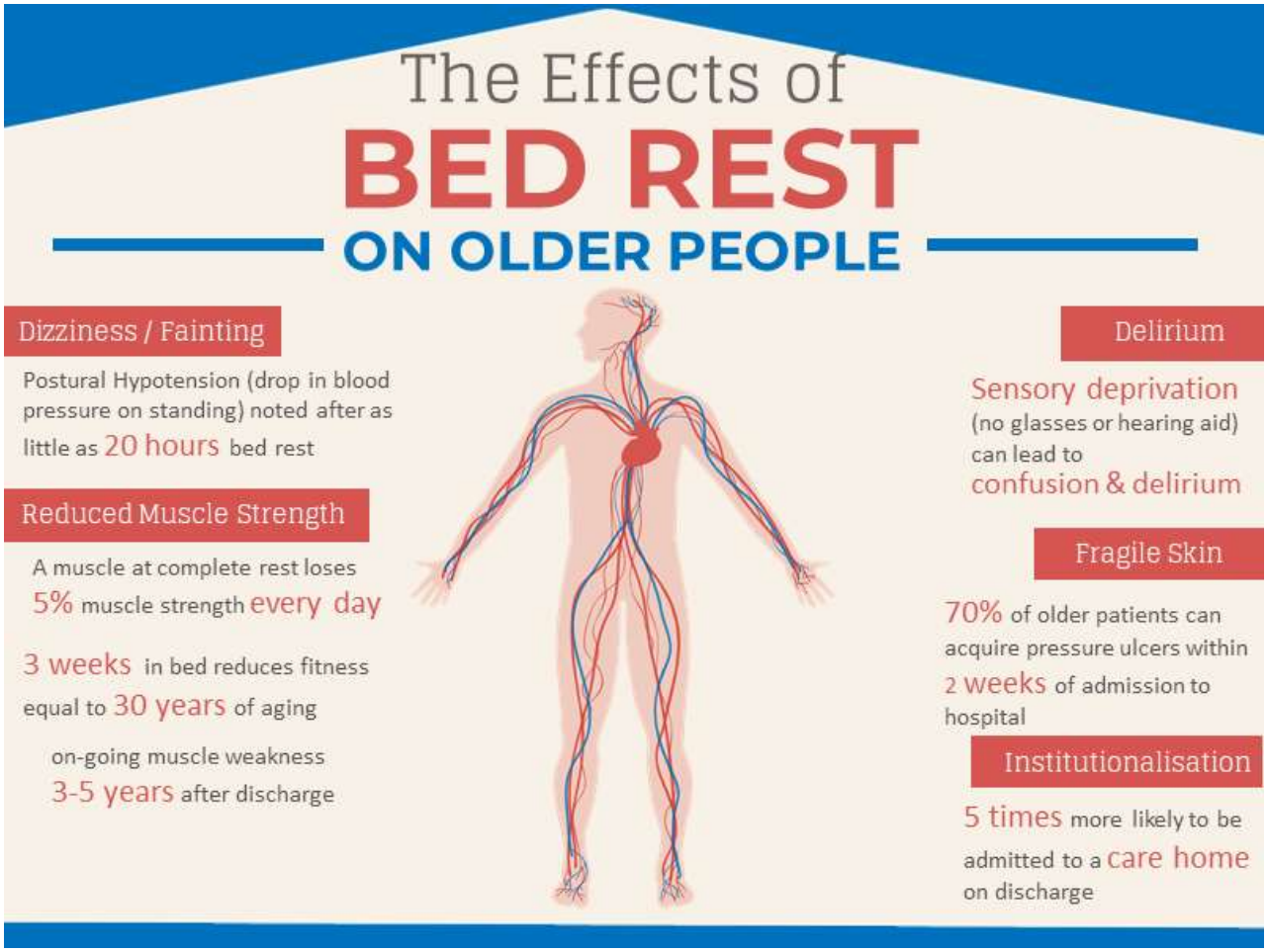
Public Health Scotland (PHS), provided data on average lengths of stay, including the periods before and after the ready for discharge date. Much is known through delayed discharge data about the length of delays but it was striking how long people had been in hospital prior to being ready for discharge.




Work in one partnership found the average length of stay in an acute hospital was 5.1 days. For patients who went on to become '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 may not always be down to the presenting illness but rather to the 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.




There are already a number of campaigns aimed at reducing the effects of bed rest, perhaps 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”. This requires a cultural shift to move 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.

### 11.1 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.

- A 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.

## 12. Outcomes and Data

The working group considered a range of data, both existing and desired, which were subsequently discussed with PHS. A number of additional data pieces were supplied for consideration by the group. The data was not consistent and in many cases did not allow the group to make fair and reasonable judgements. There is a requirement to understand data currently collected and supplied, their definitions and usefulness before commissioning wider and ongoing future collection.

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 discharge, 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 noting that '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 may have prevented the discharge of patients considered ready for discharge. Accurate recording of data, verified locally and signed off, as per the current PHS guidelines, by the HSCP Chief Officer or nominated representative, is fundamental to managing delay.

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.

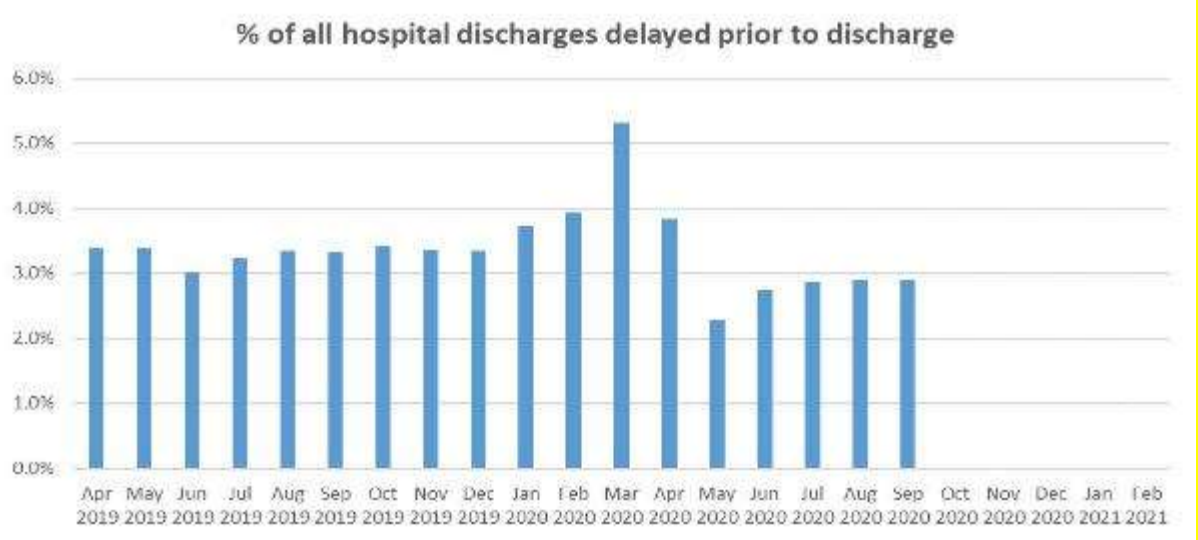
It is also important that the code accurately reflects the reason for delay. For example, for planning purposes it will be important to know if someone is waiting for a specialist dementia bed rather than a nursing or other residential care place. Equally, it is important to separate delays awaiting 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 intelligence reflecting how the system is working, so it is 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.




## 12.1 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 expert group should be shared as management information to partnerships, and a summary published within PHS' annual report.

## 13. Communication

We talk about communication in several ways throughout this document. 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 adopted during the pandemic, making best use of digital technology. Daily face to face, multi-disciplinary huddles are perhaps no longer needed or the best use of time, requiring 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 moment a patient is admitted to hospital, the multi-disciplinary team, along with the patient, family and carers should begin to develop an understanding and expectation of what is going to happen during the stay in hospital. Discharge planning conversations are important to 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.

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' or other digital tools 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 is clinically appropriate, with all parties clear that remaining in hospital after this point is not appropriate or clinically optimal. 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, often what is *not said* is equally important. Ward staff should carefully guard against discussions about post-hospital support that might inappropriately raise expectations. The key messaging should be that 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 of 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_centred 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 could be used 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 timeliness and 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, creating 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.

### 13.1 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.

## 14. Enablers

### 14.1 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.

### 14.2 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.

### 14.3 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 self-management 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.

### 14.4 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.

### 14.4.1 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.

### 14.5 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

## 15. Recommendations

This guidance provides a framework to enable NHS Boards and Health and Social Care Partnerships to develop a consistent approach to discharge planning which supports patients to access the ***right care, in the right place***.

- This guidance should be viewed alongside the implementation handbook and adapted to complement local services and regional requirements

It is recommended this key actions in this guidance are adopted nationally by NHS Boards and Health and Social Care Partnerships across Scotland, to ensure consistency of approach. This is supported by local and national campaigns with this branding.

## 16. Next Steps

### 16.1 Additional Support

The Discharge without Delay Project Team will be working to implement the recommendations from this paper with NHS Boards and Health and Social Care Partnerships.
For further information or to discuss please contact:
Andrea Jamieson, Head of Programme – andrea.jamieson@gov.scot
Brian Slater, Head of Home First Team – brian.slater@gov.scot

### 16.2 Guidance feedback and further questions

If you have further questions or would like to provide feedback, please contact one of the above.

## Annex A: List of those on the group

| Name | Role and Organisation |
|---|---|
| Julie White (Chair of overarching Group) | Chief Officer, Dumfries and Galloway Health and Social Care Partnership |
| Brian Slater (Co-Chair) | Home First, Scottish Government |
| Dot Jardine (Co Chair) | Discharge Manager, NHS Greater Glasgow & Clyde |
| Marianne Hayward (Co Chair) | Head of South Lanarkshire HSCP |
| Chris Connolly | Discharge Services Lead, NHS Lothian |
| Ann Murray | Telecare lead, Tec Team, Scottish Government |
| Lynne Morman | Discharge Lead, Dundee City |
| Deirdre Gallie | NHS Forth Valley |
| Brian Paris | Chief Social Worker, Scottish Borders |
| Fiona Wilson | West Lothian Health and Social Care Partnership |
| Ian Logan | Consultant and Clinical lead in Medicine for the Elderly, Angus Health and Social Care Partnership |
| Karen Burns | Home First, Scottish Government |
| Maxine Ward | Senior Manager, East Ayrshire Health and Social Care Partnership |
| Patricia McGinley | Discharge Lead, NHS Greater Glasgow & Clyde |
| Isla Bisset | Home First, Scottish Government |
| Grace Cowan | Head of Primary Care and Older Peoples Services, Midlothian Health and Social Care Partnership |
| Alan Brown | Service Manager, Inverclyde Health and Social Care Partnership |
| Lisa Reedie | Principal Information Analyst, Public Health Scotland |
| Amanda Trolland | Programme Manager, Unscheduled Care |
| Michael Fox | Improvement Advisor, Unscheduled Care |
| Marese O'Reilly | Project Manager, Unscheduled Care |
| Danielle Brooks | Policy Officer, Unscheduled Care |
| Merrel Veitch | Project Support Officer, Unscheduled Care |

## Annex B: Recommendations to Systems Leaders

In 2020, the Unscheduled Care Team brought together a group of experts leading on, or involved with planning, preparing for and enabling discharge across the whole Health and Social Care system. This expert group were asked to explore and define 'what works well' across the country in relation to discharge planning and the use of Home First or Discharge to Assess.

This expert group under the leadership of Julie White, Chief Officer from NHS Dumfries and Galloway and Brian Slater, Head of the Scottish Government's Home First Team, authored a discussion paper which contained a set of guiding principles and high level **recommendations for Health and Social Care Systems Leaders.**

The Integrated Unscheduled Care Steering Group accepted the findings and recommendations, and an improvement programme has been created to take forward the 6 high impact changes to deliver ***'Discharge Without Delay'*** taking a 'Once for Scotland' approach.

- Provide overall leadership and ensure delay is **prevented**, time to plan and prepare is **protected**, and Home First is a **priority** for all staff
- Facilitate changes in culture and behavior to promote home as the primary discharge destination
- Ensure early agreement of a Planned Date of Discharge that all parties work together towards
- Promote proactive discharge planning and multi-disciplinary discharge rounds
- Provide optimal care of patients while in hospital to reduce functional decline
- Avoid discussion about long-term needs in an acute setting. Focus on the patient going home
- Set performance expectations and ensure proper monitoring and evaluation mechanisms are in place
- Promote application of standardised assessment practices
- Allocate and align resources to maximise system effectiveness
- Conduct capacity assessment and promote shift away from institutional care by increasing capacity of community sector as appropriate
- Oversee strategy and communicate system objectives and expectations
- Focus on what the patient can do, rather than what they can't do. When talking about home focus on what they have, rather than what they need

## Annex C: The Pathway Based Planning Model

## Annex D: Driver Diagram