In relation to:
Venables' Proof of Evidence para 4.5 & 7.14 and Derbyshire's Proof of Evidence para 6.13

Reducing long stays: Where best next campaign

Why not home? Why not today?

It's much better for a patient's physical and mental wellbeing to leave hospital as soon as they are medically optimised for discharge. There's lots of evidence to support this. Yet each year, nearly 350,000 patients spend more than three weeks in acute hospitals.

This is why it's so 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. Think 'Why not home? Why not today?' every day.

Making this happen is a team effort and we all have a part to play. As healthcare professionals, there are several practical actions you can take to help get patients to the best place for them.

The five key principles

NHS England and NHS Improvement have 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.

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The five 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

Key actions for different roles

Underneath each key principle there are specific actions relevant to different healthcare professionals.
By following these actions and thinking 'Why not home? Why not today?', we can reduce long stays and get patients to the best place for their recovery.

Other practical things you can do

- Learn from case studies of other hospitals who are already successfully delivering a reduction in long stays
- Use the Plan, Do, Study, Act (PDSA) approach to pilot new approaches
- Explore the resources available to help you
- Find further information and useful links.

Principle 1: Plan for discharge from the start

From the outset of a patient's admission, the multidisciplinary team leading their care, plus the patient, their family and carers, all need to have a clear expectation of what is going to happen during their stay. Reducing unnecessary patient waiting should be a priority for all teams, with a patient's time being viewed as the most important currency in healthcare.

As a first step, all patients' cognitive, functional, and social status should be assessed prior to admission and on admission. Where possible, therapy input should also be increased in emergency departments and acute medical assessment units so patients can be assessed immediately, and a comprehensive geriatric assessment can be undertaken for people with frailty.

The first consultant contact may be the most appropriate time to set the Clinical Criteria for Discharge (CCD) and Expected Date of Discharge (EDD). However, this should be set no later than the first consultant post-take ward round the next morning.
The CCD is the minimum physiological, therapeutic and functional status a patient needs to achieve before discharge.

You should include a 'functional' element within the CCD. This is essential for older patients, who are more likely to have frailty or impairments to their daily living. The healthcare professional must be reflective of the patient's 'norms' rather than any generalised expectations. For example, a patient with dementia, reduced mobility and a normal exercise tolerance of 25 yards may indicate not meeting the criteria to reside and will be fit for discharge if their toilet is only five yards from their bedroom, they are mobile with a frame and they have the supervision of one person.

It is important to anticipate that patients will continue to recover at home with or without support. In fact, many patients need to leave the hospital to be able to complete their recovery fully.

Objectives should be set and reviewed every day. This should not be about one team or one healthcare professional assuming responsibility – it should truly be a multidisciplinary approach.

This process streamlines the transfer of care from the beginning of the inpatient journey, taking social care requirements and the risk of overprescribing community care into consideration.

If necessary, the EDD can be adjusted. However, it is crucial that you set the EDD assuming an ideal recovery pathway unencumbered by either internal or external waits, so that these aren't hidden.

The CCD and EDD are essential care coordination tools. They are not tools for hospital management – they are there to support clinicians and patients. However, one of the key benefits of using the CCD and EDD is that hospital management can clearly identify where there may be unnecessary waits and focus on resolving these. What's more, having plans in medical notes that include clear clinical criteria for discharge make it easier for non-medical teams to implement criteria led discharge. It may appear more straightforward to implement this process for elective, surgical patients than for those admitted as an emergency. However, it is possible to do it for both, and all hospitals must have a policy in place. Even if a patient is only expected to stay for two days or less, you should still expect to set an EDD. The flexibility of this approach to discharge planning makes it suitable for all patients, regardless of the complexity or severity of their condition.

Links to further resources

- Rapid Improvement Guide to EDD and CDD
- EDD and CCD video
- Criteria led discharge programme

Principle 2: Involve patients and their families in discharge decisions

Patients, their families and their carers often have misconceptions about the benefits of staying in hospital (although as revealed in the Healthwatch Report 2017, a significant number also feel trapped in hospital).
As healthcare professionals, we can occasionally make decisions for a patient based on our belief of what's in their best interest, without fully involving the patient, their family and carers.

No patient should feel that they are being prematurely discharged from hospital, but nor should they be kept in hospital unnecessarily. So, it's vital that patients:

- Understand the psychological and physical benefits of being out of hospital
- Are equipped to make an informed decision
- Have an appropriate prescribed community care package, if necessary

Patients and families need to understand that long stays in hospital can lead to worse health outcomes and can increase long-term care needs. This is particularly relevant for older patients. Teams should be able to have high quality conversations to explain this.

We should ask patients what matters to them, gather information from paramedics, carers and family and ensure that this information is documented clearly and that it stays with them throughout their hospital journey.

Ultimately, everyone involved (especially the patient and their family) should be able to answer four key questions:

1. What is the matter with the patient (or what are we trying to exclude)?
2. What have we agreed we are going to do to help the patient's recovery – now, later today and tomorrow?
3. What needs to be achieved to get the patient out of hospital (i.e. what are the CCD)?
4. If recovery is ideal and there is no unnecessary waiting, when should the patient expect to go home?

Using these four questions helps ensure that each patient's plan is personalised and tailored to their individual needs, and that they and their families (and carers) can drive their own care and ask informed questions.

Use conversations with the patient and their family or carer to ensure that arrangements are made for patients to be able to get into their home and have heating and food available.

It's recommended that all sites have a training approach in place to help staff have open discussions with patients, their families and carers about the options available

and the potential outcomes. The Gold Standards Framework can provide useful training on this issue.
Getting patients up, dressed and moving during hospital stays has been shown to reduce falls, improve patient experience and reduce length of stay by up to 1.5 days. Find resources and more data on this subject at the PJ Paralysis website.

Links to further resources

- Reducing Long Hospital Stays videos
- Patient choice guide
- Patient choice resources
- End PJ Paralysis
- Healthwatch report 2017

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Principle 3: Establish systems and processes for frail people

Frailty is one of the most challenging consequences of population ageing. Frailty develops as a consequence of age-related decline in multiple body systems, which results in vulnerability to sudden health status changes triggered by minor stress or events, such as an infection or a fall at home.

Between a quarter and half of older people are estimated to be frail. However, frailty is a gradual state and many younger people can also be considered to be in the early stages of frailty.

As healthcare professionals, it is our role to support people living with frailty to maintain their health for as long as possible. We know that frail older people tend to have a longer length of stay, which can lead to complications and worse health outcomes, with an increase in their long-term care needs. So, for their wellbeing, we need to minimise this as much as possible.

We need to ensure that frail older people are discharged immediately once their acute care is complete, with the right level of support to continue their recovery and rehabilitation in their own home.

Ensuring that there is a comprehensive geriatric assessment in place is fundamental to this. This assessment could be carried out as an in-patient or on arrival at hospital and followed up at home.

Key steps to successfully establishing a frailty pathway include:

- Ensuring there is a rapid response service in place to support frail older people to avoid unnecessary hospital admissions
- Identifying and measuring frailty from the moment the patient enters the 'front door', using an evidence-based assessment tool (e.g. by using the Rockwood Clinical Frailty Score)
- Having a multidisciplinary team that is competent to deliver a holistic assessment and management of older people (through a Comprehensive Geriatric Assessment) early in the patient pathway
- Engaging with a single assessment process and patient record which is completed by the whole team
- Involving patients and their families (and carers) in their care – they should routinely be asked what matters to them, and their responses clearly documented

Links to further resources

- Frailty video
- The Value of Patient Time: Last 1000 Days

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- Rapid Improvement Guide to managing and identifying frailty
- Rockwood Clinical Frailty Score

Principle 4: Embed multidisciplinary team reviews

Organisations should ensure they have adequate discharge services, seven days a week.

All patients' physical and mental health status, medication needs, nutrition and hydration status, and limited functional assessments should take place in the acute setting. This information is shared with the multidisciplinary team who will describe the support the patient requires once they are discharged or transferred. The following steps will ensure the best outcomes:

- Carry out multidisciplinary reviews of all patients twice a day
- Make sure all patients have a board round every day
- Hold reviews as often as necessary, ensuring outstanding actions for the day are completed and results of requested investigations are actioned

You should be aiming to:

- Review the patient's functional and physiological status
- Identify a plan for the patient including a discussion around all possible discharge options
- Establish what the patient is waiting for
- Work out how any constraints or barriers can be removed.

The outcomes of the multidisciplinary meeting should be shared with patients and their families or carers.

There should be an effective escalation process to ensure constraints causing unnecessary patient waiting are removed. Following confirmation of a medical decision to discharge, transfers from the ward or unit to the designated discharge area should happen promptly. This should be within one hour of that decision for patients on Pathway 0, and the same day for people on all other pathways. Discharge from the discharge area should happen as soon as it is possible and safe – often within two hours, or on the same day (preferably before 5pm).

The systematic use of weekly long-stay patient reviews can reduce the number of in-patients with a LOS exceeding 20 days by up to 50%.

These reviews introduce supportive challenge and help ward multidisciplinary teams consider criteria led discharge for patients who no longer meet the criteria to reside. Any member of the multidisciplinary team (e.g. junior doctor, nurse or allied health professional), can enact without the need of a consultant but arrangements should be in place to contact them if needed.

The review should be carried out on the ward, led by a senior member of staff. Any assessment of short and long-term needs should happen in the community via the 'Discharge to Assess' model. There should be a case manager assigned to each system to facilitate timely discharge.

Reviews should capture both qualitative and quantitative information on the reasons for the wait, with a report compiled from all the material gathered. They should aim to identify:

- Why patients are in hospital for seven days or more
- Recurring themes (and where possible, patient characteristics) so patient groups can be identified earlier in the future, and the chance of an extended stay is reduced
- Areas of good practice
- Areas with the opportunity for improvement

The outcomes from the report should be used to ensure that lessons learnt or questions still to be answered can be built into internal actions and local system action plans.

We need to identify the reasons behind stays of seven days or more and the actions which can be taken to avoid delays. By doing so, we can help significantly reduce deconditioning and second and third phase illnesses.

Links to further resources

- Reducing long hospital stays guide

Principle 5: Encourage a supported 'Home First' approach

Take a 'Home First' approach, providing patients with support at home or intermediate care. Wherever possible, patients should also be supported to return to their home for assessment. Evidence available on local.gov.uk and gov.uk suggests that this can help with the over-prescription of care, which often happens when patient assessments are undertaken in hospital.
Implementing a Discharge to Assess Model (D2A) where going home is the default pathway (with alternative pathways for people who cannot go straight home) is more than good practice – it is the right thing to do.
Staying in hospital for longer than necessary has a negative impact on patient outcomes. Ensuring that patients are given the chance to continue their lives at home is vital for their long-term wellbeing outcomes.

There is no 'one size fits all' model that will deliver D2A. What is required can be described as a 'complex adaptive system' which involves simple rules, rather than rigid inflexible criteria.

However, there are some core principles that you should follow when establishing a model in your area:

- D2A should be free at the point of delivery, regardless of ongoing funding arrangements.
- For the patient's safety, the assessment should be done promptly (within two hours of arriving home), with rapid (on the day) access to care and support if it is required.
- Ongoing support services should be time-limited to up to four weeks . The government has agreed to fund, via the NHS, up to four weeks of care for new or additional needs of an individual on discharge from hospital, where care is delivered up to and including 31 March 2022. The needs of the individual will determine the availability and the period of funded support, which may be less than four weeks depending on when it is appropriate for post-discharge recovery and support services to cease because the person has recovered, or long-term care has been put in place following relevant assessments.
- D2A should be a non-selective service that tries to always say 'yes' – including support for end-of-life care.

To get started, use Plan, Do, Study, Act (PDSA) cycles to test new ideas rapidly, monitor closely, learn and develop. Starting small and growing is more effective and achievable than trying to change the entire system all at once.
There are also some excellent examples from around the country of how different hospitals and the social care partners have implemented this.

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Links to further resources

- Plan, Do, Study, Act model
- Quick Guide: Discharge to Assess

Taken from: NHS England » Reducing long stays: Where best next campaign