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Social Care Policy and Delivery Division

Scottish Government
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Dear Colleagues

We have recently established an Expert Support Group on delayed discharge, which is currently meeting weekly to discuss barriers to further progress and how systems can be supported to overcome these. In addition a work stream, chaired by Julie White, Chief Officer, Dumfries & Galloway HSCP is also looking at discharge arrangements under the Redesign of Urgent Care programme.

In the coming weeks, we anticipate the Expert Support Group will make available a number of resources that include a set of principles/standards to support effective planning of care and discharge. In the meantime, and notwithstanding that both these two groups will want to discuss a wide range of solutions, there are several ideas emerging that the Cabinet Secretary, following discussion with Councillor Stuart Currie, COSLA Spokesperson for Health and Social Care, is keen are progressed without delay. These are:

Embedding a Home First approach

Almost all Health and Social Care Partnerships have introduced a Home First approach, a simple ethos that a person's own bed is the best bed and that people will recover from illness better and faster at home. However, full and effective implementation requires a major cultural shift in some deep rooted beliefs and behaviours of the public and health and care providers, to build on the principle that people want to go home and that they will best recover and recuperate there. Where previously long-term needs were assessed in an acute setting, an individual should be supported home and an assessment of need carried out in familiar surroundings. While in an acute setting, any discussion should be "strength based", focussing on what an individual can do rather than what they can't do, and any assertion than the person will not return to their own home should be avoided.

It is important that we also make optimal use of community hospitals and intermediate care facilities. These should be used for people who might need rehabilitation or reablement to help return them home. They can also be important for providing a more appropriate setting to assess someone's longer-term needs where it is not possible to do this in the individual's own home.

Intermediate Care and Hospital at Home

The Cabinet Secretary has on several occasions highlighted her interest in seeing hospital at home services developed across Scotland, and work is ongoing within Healthcare Improvement Scotland to support a number of areas take developments forward.

Hospital at home is one of a range of Intermediate Care services, including rapid response admission avoidance, step-up / down beds, virtual wards and Enhanced Care at Home, that can provide alternatives to an acute admission, and support timely discharge home. Intermediate Care services cannot be effectively developed or run in isolation to other mainstream services, or each other. Effective integrated intermediate care services should form an integral part of the wider suite of health and community care services available in the locality.

This is particularly true for hospital at home services which require rapid access to diagnostics, labs and other hospital based services.

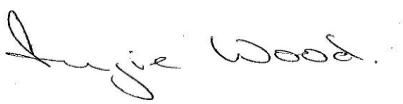
Planned Date of Discharge

More than just a change of wording, rather a change in emphasis from Estimated Date of Discharge to Planned Date of Discharge, which should be an agreed date and plan for discharge that the multi-disciplinary team, as well as the patient, family and carers, are involved in. In terms of holistic assessment, on-going care and support needs it is important that planning starts early and that all parties actively work towards the Planned Date of Discharge and not from the Date of Discharge.

Whole system management

Systems that are making progress have identified a senior individual or team (such as a discharge hub) to work across integrated services and acute hospitals to tackle the delayed discharge problem, identifying solutions and driving sustainable change. The Cabinet Secretary and Councillor Currie are keen to see such an approach in every partnership. Adopting 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 of risks. They should be able to cut through bureaucratic red tape and ensure there are no valid impediments to timely discharge home. In addition, they should ensure longer-term sustainability and that delayed discharge be seen as a collective responsibility rather than one person's or one team's.

Finally, we attach two papers to clarify roles and responsibilities. It is important that people respect the boundaries of their own roles and responsibilities, and those of other team members.



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HOME FIRST – INDIVIDUAL RESPONSIBILITIES

Home First challenges healthcare professionals in hospital to undergo a cultural shift and recognise that home is the best place for people to recover and rehabilitate. This approach requires hospitals to work with community partners to proactively plan a patient's discharge and jointly agree a planned date of discharge in every case as soon as possible.

Home First needs to be linked to a Discharge to Assess approach. Unless unavoidable, an assessment of longer-term needs should never take place in an acute hospital. As "Realistic Medicine" describes, "doctors prescribe more care for their patients that they would for themselves". The same can be said for allied health professionals and social care professionals. Studies in England have found that two in every five people have their needs over prescribed when assessed in hospital. They further found that one in three care home placements could have been avoided had the right support been available.

People should be supported back home where an assessment can then take place among familiar surroundings. Where this is not possible, a period of intermediate care in a step-down facility should be considered, for the individual to be rehabilitated and reabled to return home from there.

Clinical support for Home First is critical. The voice of the doctor is most likely to be the one influential voice that the patient and family hear. It is imperative therefore that the focus is always on going home and that premature discussions about long-term care are avoided when the patient is at their most dependent in an acute setting. Clinicians can play a key role in alleviating any fears the patient may have about receiving care at home and must reassure their patients about the benefits of going home.

Individual roles and responsibilities

To achieve and maintain a strong relationship, each party should clearly understand the elements of the Home First approach as well as the key role that they play during its implementation.

As with any collaborative working, everyone needs to know their own roles and responsibilities, while respecting those of others in the team. While everyone will have distinct roles and responsibilities, it is important to work as "one team" and to work together towards agreed, shared goals with a common sense of purpose.

Home should always be the default position for people, and all staff, at all points in the patient's journey, should ask "why not home, why not today?" with the aim of returning people home without any needless delay.

Leading roles and responsibilities in discharge arrangements are summarised below:

Patient, family and carers

- Should be fully engaged in the discharge process from the earliest stage
- Should be given information, advice and support about the discharge process, including access to independent advocacy services
- Support the need for timely discharge and avoid unnecessary barriers and delays

All staff

- Should be consistent in the messaging that patients should go home and that remaining in hospital is not an option
- Ensure the involvement of family and carers in discussions about care needs
- Agree a Planned Date of Discharge
- Work on discharge arrangements **towards** the planned discharge date and not **from** it

The clinician

- Assess when someone is clinically ready for discharge (as part of MDT process)
- 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 enablement and management
- Ensure timely production of Immediate Discharge Letter
- Ensure prompt arrangements of any discharge medicines
- Ensure that all infection prevention and control measures are followed per HPS guidance

Nursing and ward staff

- Ensure effective and inclusive engagement with the patient, family and carers throughout the discharge process
- Senior Charge Nurse will use their expertise in discharge planning in line with Home First principles and practice
- Ensure discharge planning starts as early in the process as possible
- Liaise with social work staff to ensure early notification of people who might need on-going support
- Provide information and advice to ensure people have realistic expectations of care
- Keep patients as active and stimulated as possible to avoid deconditioning

Social Work staff

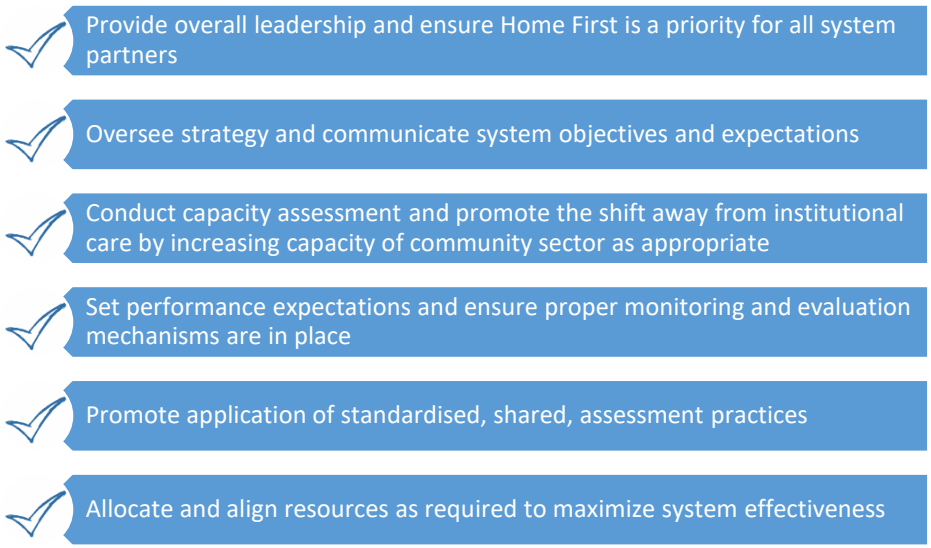
- Ensure discharge planning starts as early in the process as possible
- Support family and carers through the process
- Commission provision of on-going community support where required
- Ensure a reablement approach is taken and avoid unnecessary delivery of care
- Lead the completion of assessment of ongoing need and supports, post-discharge from hospital

Hospital Discharge – Implementing Home First: Corporate responsibility

Successful implementation of Home First requires extensive collaboration between hospital, primary, social work and social care services. Every party involved must take full responsibility for implementing and sustaining the Home First approach. Working together effectively will facilitate the necessary cultural shift and process changes required to fully implement Home First.

Integration Authorities

Integration Authorities are responsible for the planning and commissioning of health and social care services. As such, the Integration Authority's role within Home First is to oversee the Home First strategy and provide overall leadership and garner support from all relevant stakeholders (i.e. hospitals, social care, care homes, primary care and the third and independent sector). This includes ensuring that Home First is a top priority, and that all staff are committed to reducing admissions to long-term care, avoiding unnecessary hospital admissions, and reducing long-term care demand.

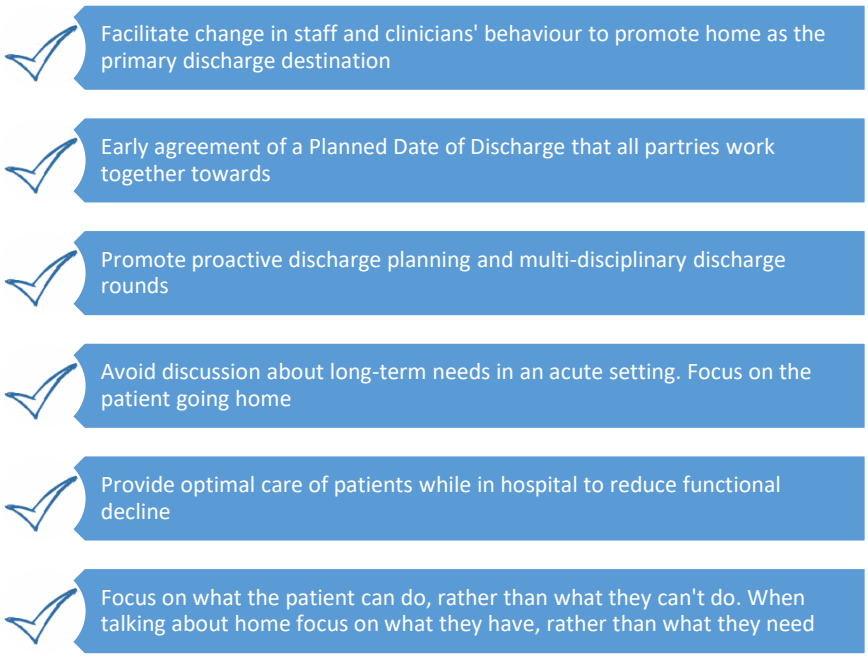


Integration Authorities must also ensure continuous monitoring and evaluation of Home First and ensure that the necessary reporting structures are in place to take corrective action as needed.

Integration Authorities must play a role in creating more public awareness about Home First and managing expectations, ensuring patients properly understand the discharge process and benefits of going home. In doing this, Integration Authorities must ensure that consistent messaging is being provided by all staff with respect to Home First.

Hospitals

The hospital is the operational ground for Home First and the main site where a cultural shift will be necessary. As such hospitals need to ensure all staff, including clinicians, nursing, AHPs and social care workers, fully embrace the philosophy and have robust communication and education plans in place.



Home First challenges healthcare professionals in hospital to undergo a cultural shift and recognise that home is the best place for people to recover and rehabilitate. This approach requires hospitals to work with community partners to proactively plan a patient's discharge and agree a planned date of discharge as soon as possible. Discharge planning should work **towards** the discharge date and not **from** that date. Hospitals should continuously monitor and report on Home First performance and take corrective actions where necessary.

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.

Primary Care

Primary care clinicians are 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.

GPs should also actively monitor their patients while they are recovering and receiving care at home to ensure timely recovery and avoid unnecessary readmissions to hospital.

People

Patients should be treated as partners in decision making. Most people want to be in their own homes, in their own beds at night, and proper cognisance needs to be taken of their wishes. While taking full recognition of people's wishes and choices, remaining in hospital after treatment is fully complete should not be an option.

ENSURING BUY-IN TO HOME FIRST

To effectively realise a cultural shift, those who will be most impacted by the shift need to be engaged throughout the implementation process.

Clinical Staff

Clinicians in the hospital and community should be targeted separately 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 rests 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.

Nurses

Nurses are often 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 their questions and reassure them of their 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.

Social Workers and 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 Home First processes.

Social Work, social care and allied health's engagement is essential since they are an important part of team and facilitate the discharge home and provide patient care in the home.

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.

Clinical Leadership

Clinical leadership's 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.