



# Life beyond the ward

**Recommendations** for  
improving hospital discharge in  
**Scotland**

# Introduction

This discussion paper outlines key findings from the experiences of people being discharged from hospital, based on research in Scotland. The research was conducted as part of a UK-wide study, the breadth of which is explored in the British Red Cross report, *Home to the unknown: Getting hospital discharge right*.<sup>1</sup>

The British Red Cross has a proud history of working in partnership with the NHS in health and social care, and plays a unique role in providing health and social care services in the UK. Our volunteers and staff work in hospitals, people's homes and the gaps in between, providing person-centred support, simple acts of kindness and non-clinical interventions that make all the difference to patient care, recovery and outcomes. They support patients in hospital emergency departments, provide ambulance support, help people to get home from hospital, carry out home assessments, and support older and vulnerable people to live independently at home. Our work addresses some of the immediate operational challenges facing the NHS and the wider care system today.

Through this work we witness the strain the NHS and care system are under and the impact this can have on vulnerable individuals. We believe that safe, well-planned discharge can make all the difference to an individual's recovery – as well as preventing re-admission, improving the flow of patients through the system and reducing costs to the health and social care system.

The findings in this paper reveal that, despite a wealth of guidance on 'ideal' hospital discharge and examples of excellence and

good practice, problems persist. Discharge processes vary considerably within local areas. While patients might appear medically fit for discharge, their wider, non-clinical needs can go unmet, resulting in future avoidable hospital admissions.

It is essential that we get the return home from hospital right. This paper lays out our research findings on the way that patients are discharged from hospital, and their return from hospital to home, and our key recommendations to tackle these issues. The research and recommendations build on existing guidance and our own operational insights. They aim to ensure that patients are set up to make the best possible recovery once they leave hospital.

## The health and social care landscape

Scotland's health and social care landscape has seen significant transformation, with the overarching 2020 Vision and the subsequent legislative change through the Public Bodies (Joint Working) (Scotland) Act<sup>2</sup> delivering significant structural change. Since then, reforms have continued through policy frameworks such as the *Health and social care delivery plan*<sup>3</sup> and, most recently, the *Social care support reform vision*.<sup>4</sup> All these programmes aim for everyone to be able to live longer, healthier lives at home, or in a homely setting.

Scotland's National Performance Framework<sup>5</sup> sets the well-being of the Scottish population at the heart of government decision-making and action. The Scottish government's success in health and social care is

<sup>1</sup> – British Red Cross and Revealing Reality (2018). *Home to the unknown: Getting hospital discharge right*. London: British Red Cross. [redcross.org.uk/hospital-discharge](https://redcross.org.uk/hospital-discharge) (accessed 21 August 2019).

<sup>2</sup> – Public Bodies (Joint Working) (Scotland) Act 2014. [legislation.gov.uk/asp/2014/9/contents/enacted](https://legislation.gov.uk/asp/2014/9/contents/enacted) (accessed 21 August 2019).

<sup>3</sup> – Scottish Government (2016). *Health and social care delivery plan*. Edinburgh: The Scottish Government. [gov.scot/publications/health-social-care-delivery-plan/](https://gov.scot/publications/health-social-care-delivery-plan/) (accessed 21 August 2019).

<sup>4</sup> – Scottish Government (2019). *Social care support: An investment in Scotland's people, society, and economy. Our shared vision for adult social care support, including support for carers*. Edinburgh: The Scottish Government. [gov.scot/publications/social-care-support-investment-scotlands-people-society-economy-shared-vision-adult-social-care-support-including-support-carers-partnership-programme-support-local-reform-adult-social-care](https://gov.scot/publications/social-care-support-investment-scotlands-people-society-economy-shared-vision-adult-social-care-support-including-support-carers-partnership-programme-support-local-reform-adult-social-care/) (accessed 21 August 2019).

<sup>5</sup> – Scottish Government (2019). *National performance framework*. [nationalperformance.gov.scot/](https://nationalperformance.gov.scot/) (accessed 21 August 2019).

measured by nine specific outcomes and six national indicators outlined by the National Performance Framework, including the number of acute unplanned bed days and delays in discharging people from hospital.<sup>6,7</sup>

The latest of the three national performance audits of health and social care integration by Audit Scotland<sup>8</sup> found that the health and social care system had made progress on four out of the six indicators, notably by reducing the number of acute unplanned bed days as well as the number of delays in discharging people from hospital.<sup>9</sup> However, the number of emergency hospital admissions and A&E attendances increased over the same period, which suggests that care is still predominantly provided in hospital settings and not in the community.<sup>10</sup>

While the reduction of delayed discharges between 2016/17 and 2017/18 – by more than 30,000 bed days – is an improvement, over 494,000 bed days are still unnecessarily occupied annually due to delays in discharge. This costs the system an estimated £125 million.<sup>11</sup> Indeed, at any time in 2017/18, one in 13 beds were occupied by people who could have been discharged from hospital.

The audits also acknowledged the challenging environment that health and care services are operating in and recognise that more needs to be done to tackle these challenges. In particular, financial planning across health and social care has not been integrated, and there is a lack of focused long-term planning. This is compounded by ongoing financial pressures across services. In addition, a lack of collaborative leadership

and strategic capacity, disagreement over governance arrangements and a lack of information sharing between organisations are all highlighted by the Audit reports as challenges that need to be addressed.<sup>12</sup>

## Getting hospital discharge right

Tackling delays in discharging patients will be critical to shifting the focus of care from hospital-based environments to community care settings, as intended by the Scottish government.

There is a wealth of guidance and documentation on the best practice in discharging from a range of organisations, including the National Institute for Health and Care Excellence (NICE), NHS Scotland, the Scottish government and the Royal College of Physicians. These highlight the following key principles for hospital discharge processes.

- Patients should be discharged at the best time for them and for the system; this should result in increased morning and weekend discharges.<sup>13</sup>
- Patients should be reviewed by senior clinicians before midday.
- Discharge hub facilities, discharge prescriptions, discharge lounges, professional leadership and liaison with the ambulance service should be planned effectively seven days a week to ensure no delays in care occur.
- A multidisciplinary team (MDT) approach should be taken to discharging patients.

<sup>6</sup> – Audit Scotland (2018). Health and social care integration: Update on progress, p. 16. Edinburgh: Audit Scotland. [audit-scotland.gov.uk/uploads/docs/report/2018/nr\\_181115\\_health\\_socialcare\\_update.pdf](https://www.audit-scotland.gov.uk/uploads/docs/report/2018/nr_181115_health_socialcare_update.pdf) (accessed 21 August 2019).

<sup>7</sup> – The six national indicators are: acute unplanned bed days, emergency admissions, A&E performance (including the four-hour A&E waiting and A&E attendance), delayed discharge bed days, end of life spent at home or in the community, proportion of over-75s who are living in a community.

<sup>8</sup> – Audit Scotland (2018). Health and social care integration.

<sup>9</sup> – Audit Scotland (2018). Health and social care integration, p. 18.

<sup>10</sup> – Audit Scotland (2018). Health and social care integration, p. 18.

<sup>11</sup> – Audit Scotland (2018). Health and social care integration.

<sup>12</sup> – Scotland Audit (2018). Health and social care integration, p. 6.

<sup>13</sup> – Unscheduled Care Steering Group (2016). Emergency department capacity management guidance. Edinburgh: Scottish Government. [gov.scot/publications/emergency-department-capacity-management-guidance-2/](https://www.gov.scot/publications/emergency-department-capacity-management-guidance-2/) (accessed 21 August 2019).



- There should be clear responsibility for a professional to discharge patients in a smooth and timely manner. Criteria-led discharge promotes the delegation of discharge authority to an appropriate member of the MDT, such as a staff nurse, allied health professional or junior doctor. Patients can thus be discharged once they meet the individual discharge criteria, previously agreed by the members of the MDT and the patient.<sup>14</sup>
- There should be a clear discharge plan and date.
- The discharge co-ordinator should involve the patient and their carers/family in the discharge planning so the latter know how they can support the patient's recovery.
- Hospital staff should use a *discharge to assess* approach in order to get patients

*home first* and undertake any further required assessments in community care settings, or the person's home.

The challenge is to turn this guidance into practice. This British Red Cross research explored experiences of hospital discharge from both patient and professional perspectives, and highlights specific challenges around discharging practice, which are symptomatic of wider issues around health and social care integration in Scotland. We hope that these findings contribute in a constructive and positive way to building better working relationships between health and social care services and ultimately to improving the experiences and outcomes of people leaving hospital after a health crisis and enabling them to live better lives in their homes.

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<sup>14</sup> – NHSScotland Quality Improvement Hub (2019). Criteria led discharge. [qihub.scot.nhs.uk/quality-and-efficiency/whole-system-patient-flow/criteria-led-discharge.aspx](http://qihub.scot.nhs.uk/quality-and-efficiency/whole-system-patient-flow/criteria-led-discharge.aspx) (accessed 21 August 2019).

# Research method

This research was commissioned to better understand the way that patients are discharged from hospital, and their return from hospital to home.

The findings and recommendations in this discussion paper are based on evidence gathered by Revealing Reality, an award-winning social research agency commissioned by the British Red Cross to undertake in-depth research into the return from hospital to home, and the British Red Cross's own evidence-gathering.

We hope that this research will help fill a gap in existing data about how often patient discharge ideals are delivered, what the outcomes are for patients when they are delivered, and what outcomes patients experience when they are not.

This research provides evidence to inform health and social care policy at national and local levels. It also enables us to make recommendations for practical steps to be applied in acute and community health settings, by social care providers and by voluntary and community organisations, including the British Red Cross – individually and together, through multidisciplinary teams.

Our evidence sources:

- **In-depth interviews at home with seven families (individuals and the family and/or friends or carers) in Scotland who had recent experience of discharge after an unplanned stay in hospital.** The sample specifically focused on people who had not received social care, either because they were ineligible, unaware of its availability or turned it down.<sup>15</sup>
- **Interviews with policy experts, researcher observations of systems,<sup>16</sup> and semi-structured interviews with 30 health and social care professionals from the statutory, and voluntary and community sector based in Scotland,** including British Red Cross staff, voluntary and community sector staff, and senior stakeholders working with statutory health and social care partnerships in commissioning or policy roles.<sup>17</sup>

This discussion paper provides a summary of the findings. Our full report, *Home to the unknown: Getting hospital discharge right*, provides details of the qualitative research.

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<sup>15</sup> – In-depth interviews in people's homes with recently discharged people and key members of their support networks, such as spouses, children and friends, conducted by Revealing Reality.

<sup>16</sup> – Thirteen expert interviews with health and social care professionals, including Scottish government, conducted by Revealing Reality.

<sup>17</sup> – Semi-structured telephone interviews with health and social care professionals from the statutory, voluntary and community sector in Scotland, conducted by Nick Hopkins Consulting with Craigforth.

# Key insights from the research in Scotland

## **There is considerable variation in discharge practices across hospitals**

Our research highlighted that, contrary to the guidance on hospital discharging processes, the decision to discharge a patient was often dependent on individual clinical practice. This can lead to a variation in discharge decisions. For example, while one consultant may be willing to discharge a patient to receive intravenous antibiotics in the community at home, another consultant may prefer this to be administered in a hospital setting.

Many of the professionals' decisions about discharge were in the context of hospital-wide patient flow or were based on clinical, rather than on holistic, assessments of the patient and their non-clinical needs. Hospital care staff highlighted that the high-pressure environment in an A&E ward can force clinicians to think only of a patient's immediate medical needs, rather than considering their emotional and psychological situation.

Clinicians mentioned that they would try to disconnect themselves emotionally and physically from their patients and their needs as a coping mechanism.<sup>18</sup> Researchers were told that clinicians worked in specialist teams and rarely strayed out of what they considered to be their bounded professional role. This could result in a short-term focus in terms of the assessment and their understanding of the patient's life.

## **Lack of co-ordination and communication between hospital, primary care and social care teams**

Despite progress on the integration of health and social care in Scotland, different types and degrees of integration exist. This presents challenges in information sharing and engagement in each other's work – and

clashing priorities for budgets continue to exist.

Our research revealed that many of the challenges in co-ordination between teams stemmed from the clinical handoff, with the communication of patient needs breaking down between ward staff and those working in discharge lounges. The person or people responsible for discharge differed from one hospital to another. Often the discharge co-ordinator was based in the discharge lounge, and discharge planning was tacked onto the patient journey at the end, rather than being integral to decision-making while a patient was on a ward.

As a result, patients often reported a lack of clarity about what was driving the decision on their discharge; in more extreme cases, patients were unclear about their diagnosis during their entire stay in hospital as well the decision for them to be discharged. This lack of understanding meant that people were often unsure what the next steps were, or how best to ensure their own recovery.

*When the wife of **Arif** (56) was taking him home from hospital, she was handed her husband's discharge note in the midst of organising transport and his medication. This note detailed his experience of a fall and the diagnosis of diabetes he received in hospital. At this point, her understanding was that this was a copy for her and Arif to keep, while another would be sent to his GP.*

*On his return home, Arif waited, increasingly frustrated, for a follow-up appointment with his GP. He felt he had been "left to fend for myself." After a few days, he called to ask after his appointment and it became apparent that the GP had not received the discharge note and had no knowledge of his hospital stay. It was only at this point*

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18 – This insight came from UK-wide research, conducted for the 2018 British Red Cross report, *Home to the unknown*.



*that it was explained that the intention was for his wife to hand over the note.*

Such experiences highlight the need to facilitate more frequent in-person discussions with patients, their families and carers, about their holistic clinical and non-clinical needs. These discussions need to take place prior to discharge to improve patient experience and communication between professionals, and need to include decision-making on care options and support prior to discharge.

### **Challenges accessing social care packages and wider support**

Our research revealed that healthcare professionals within acute settings continued to have strong narratives about the problems inherent in social care. An especially persistent barrier to people leaving hospital when they were ready was ensuring the appropriate package of social care support was in place. According to the June census, 75 per cent of all delayed transfers of care

have been due to health and social care reasons, which suggests that the necessary care, support or accommodation was not in place for patients who were deemed clinically ready for discharge.<sup>19</sup> Further investigation needs to be made locally on the specific reasons for delays and these tackled appropriately.

A recent survey by Health and Social Care Alliance Scotland highlights the following key challenges for health and social care integration, from the perspective of public sector staff.<sup>20</sup>

- **Organisational challenges** arising from unclear governance and accountability arrangements and a lack of communication of strategic decisions across the whole workforce.
- **Communication challenges** due to a lack of shared information and communications technology, and human resources systems.

<sup>19</sup> – Information Services Division Scotland (2019). Delayed discharges in NHSScotland: Figures for June 2019. [isdscotland.org/Health-Topics/Health-and-Social-Community-Care/Publications/2019-08-06/2019-08-06-DelayedDischarges-Summary.pdf](https://isdscotland.org/Health-Topics/Health-and-Social-Community-Care/Publications/2019-08-06/2019-08-06-DelayedDischarges-Summary.pdf) (accessed 23 August 2019).

<sup>20</sup> – Griesback D (2019). Health and social care integration: How is it for you? Views from the public sector. Glasgow: Health and Social Care Alliance Scotland. [alliance-scotland.org.uk/wp-content/uploads/2019/05/Health-and-Social-Care-Integration-How-is-it-for-you-Views-from-the-Public-Sector.pdf](https://alliance-scotland.org.uk/wp-content/uploads/2019/05/Health-and-Social-Care-Integration-How-is-it-for-you-Views-from-the-Public-Sector.pdf) (accessed 21 August 2019).

- **Workforce challenges**, in particular high staff turnover and the high number of unfilled vacancies. Audit Scotland noted a consultant vacancy rate of 7.4 per cent, a nursing and midwifery vacancy rate of 4.5 per cent and an allied health professional vacancy rate of 3.9 per cent in hospitals, as of March 2017. This vacancy rate is currently balanced by employing agency staff members at an annual cost of £171.4 million in 2016/17.<sup>21</sup>
- **Cultural challenges** within the healthcare and social care workforce, including different ways of working and prioritisation. Acute hospital services emerged as particularly resistant to shifting from a responsive approach to a more preventative and community-based approach.
- **Financial challenges** and the requirement to make savings across health and social care compound the above-mentioned challenges to meeting the national performance targets. In 2017/18, NHS boards made a total saving of £449.1 million and met only one of the eight key national performance targets.<sup>22</sup>

Our own research provided a deeper insight into these challenges by providing concrete examples of hospital discharging practice.

An adult social worker embedded in a hospital ward highlighted how social care delays can sometimes be preventable because they originate from miscommunication or the prioritisation of short-term clinical needs by healthcare staff. An ongoing challenge for this social worker was when clinicians made assumptions

about patients needing a care home before the patient was assessed, or when healthcare professionals sent referrals from people who were ineligible for social care support.

Not all patients are eligible for free social care support as this depends on the level of need and, increasingly, funding constraints. Equally, some social care services are chargeable, including help with housework, meal delivery, laundry, shopping and attendance at day centres.<sup>23</sup> Some individuals may thus decline social care support as they might think they do not need it, may not want to increase the pressure on the health and social care system, or may not want to pay for specific social care services as they may not be provided at the quality they wish. In these cases, support may be available from voluntary sector organisations such as British Red Cross assisted discharge services. However, our research found that many clinical staff and some social care staff were not aware of these voluntary care services. This means they may miss opportunities to signpost to other services or do not know how to do so, which means that people end up relying on sometimes inadequate informal care.

**A potentially significant proportion of people who are deemed clinically fit to leave hospital are sent to a home inappropriate for their recovery**

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

<sup>21</sup> – Audit Scotland (2017). NHS workforce planning: The clinical workforce in secondary care, p. 4. Edinburgh: Audit Scotland. [audit-scotland.gov.uk/uploads/docs/report/2017/nr\\_170727\\_nhs\\_workforce.pdf](https://audit-scotland.gov.uk/uploads/docs/report/2017/nr_170727_nhs_workforce.pdf) (accessed 21 August 2019).

<sup>22</sup> – Audit Scotland (2018). NHS in Scotland 2018, p. 4. Edinburgh: Audit Scotland. [audit-scotland.gov.uk/uploads/docs/report/2018/nr\\_181025\\_nhs\\_overview.pdf](https://audit-scotland.gov.uk/uploads/docs/report/2018/nr_181025_nhs_overview.pdf) (accessed 21 August 2019).

<sup>23</sup> – Care Information Scotland (2019). Personal and nursing care. [careinfoscotland.scot/topics/care-at-home/personal-and-nursing-care/](https://careinfoscotland.scot/topics/care-at-home/personal-and-nursing-care/) (accessed 21 August 2019).



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

The Scottish government's commitment to discharge people within a 72-hour time frame is therefore welcome.<sup>24</sup> However, data from 2018 and 2019 show that very few hospitals met this target. Less than 20 per cent of all discharges were within a time frame of 72 hours in 2018 and 2019.<sup>25</sup>

As our research revealed, for people recovering from a fall it was often difficult to move about their home before their hospital stay, and when they returned they found their homes were even less suitable. Alastair's example (next page) illustrates the value of a person-centred discussion, focused on planning and prevention, as a way to prepare someone for potential future health crises.

<sup>24</sup> – Scottish Government (2019). Delayed discharge. [www2.gov.scot/Topics/Health/Quality-Improvement-Performance/NHS-Performance-Targets/Delayed-Discharge](http://www2.gov.scot/Topics/Health/Quality-Improvement-Performance/NHS-Performance-Targets/Delayed-Discharge) (accessed 21 August 2019).

<sup>25</sup> – Information Services Division Scotland (2019). Delayed discharges in NHSScotland: Figures for June 2019.





## **Alastair, 68**

### **Breathlessness, four days in hospital**

Alastair lives alone in a semi-detached bungalow in rural Scotland. He is very independent and spends much of his days browsing eBay – he has a particular love of “unusual watches.” Alastair suffers from chronic obstructive pulmonary disease (COPD) and had noticed he was starting to feel worse and worse throughout the year. Alastair believes he is not someone who is ever going to be in fully good health.

Alastair went to hospital when he was having trouble breathing in late 2018. It got to the point where he could not walk very far without becoming short of breath. He admitted that his most recent hospital visit had been a bit of a wake-up call for him.

He has seen his physical abilities decline, particularly in terms of breathlessness, which he felt had been happening more and more since his hospital stay. He has felt increasingly wary of exerting himself and has started to limit his own movement. He often drives round the car park of the local supermarket until a space near the door becomes available.

Practically, Alastair has been struggling to maintain his home. Maintaining his independence is a real concern for Alastair, as he feels that he is a naturally strong and independent character. He does not want to be a burden and believes that accessing support could undermine this independence rather than improve it. When there was a mix up with the syringes for his medication, he simply ordered some more for himself from eBay.

He was given some contact details for organisations while in hospital, but has not been keen to contact them for help. Despite

this, the day after Alastair returned home the British Red Cross visited his house to check on him. Alastair believes they had been in touch in the hospital but could not remember the meeting well. They continued the visits for the next few days, providing Alastair with information about housing options he might want to access in the future.

Even though Alastair did not take up all the help that was offered to him, he was thankful for the information he had received about what he can get when he feels ready to access the services:

“**When I got the information, I was glad I had it, that I could fall back on it.**

” Alastair

After a few days, Alastair felt he did not need their support anymore. He was feeling a lot better and did not want to be using up their time.

“**After about three days, I was feeling quite well enough to do without them and you feel like you’re maybe a drag on their time.**

” Alastair

This support had positive psychological benefits for Alastair. He felt reassured now he had someone he could get in touch with if something were to go wrong. In the past year, as his health has continued to decline, he has been increasingly worried about his future and the precautions he may need to take. The information about support that may be available to him, provided by the British Red Cross, has given Alastair more confidence in his future and his capacity to manage his health should it worsen.

Even if patients do not want to engage with services, it is essential that they are still made aware of what is available and what they entail – to encourage living independently and well at home.



“  
*It seems like giving in to your condition rather than trying to work through your condition.*  
 ”

Alastair

# Alastair's journey

## Limited mobility

Due to his declining health, Alastair struggles to walk without becoming breathless and struggles with the upkeep of his house and shopping

## Pre-existing conditions

Alastair's health has been declining over the last few years, particularly his COPD

## Awareness of services

The British Red Cross contacted Alastair to check on him and make him aware of the services it offers

## Declining health

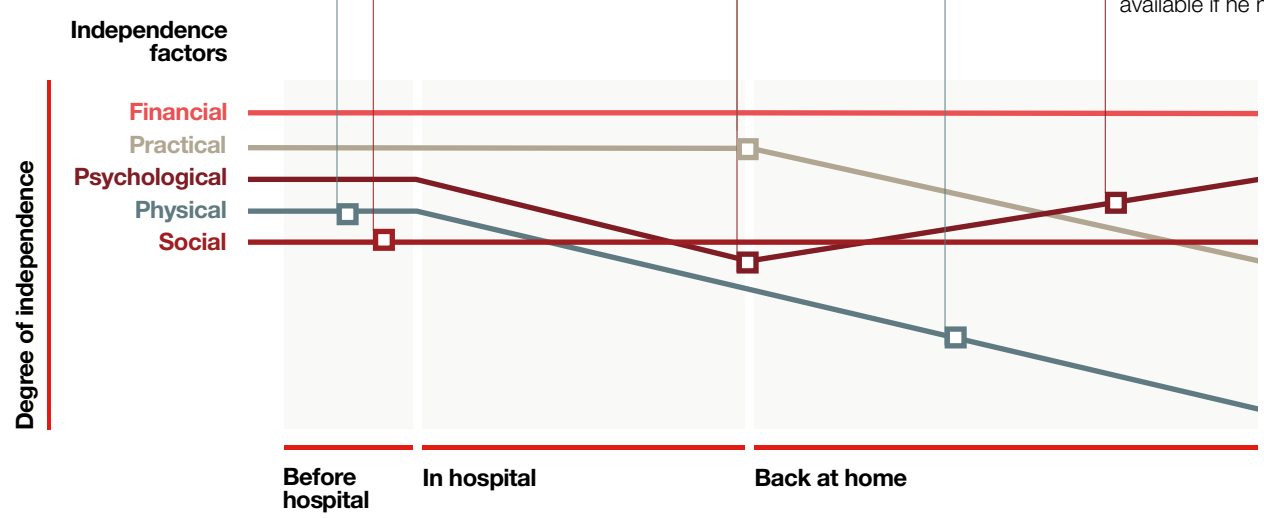
Alastair's health continues to decline after his hospital stay

## Living alone

Alastair lives alone and does not see his family often

## Confidence in the future

Alastair feels more confident knowing that there is support available if he needs it



# Key recommendations

## 1

### **Fulfilling the change to a more preventative approach to care.**

Despite recent reforms to integrate health and social care, the findings of our research, as well as the Audit Scotland reports and the Health and Social Care Alliance Scotland report, highlight that the shift from reactive and hospital-based care towards more preventative and truly community-based care has not been realised everywhere in Scotland.

Momentum needs to be maintained to make integrated care a reality. Alongside the tackling of key issues highlighted by Audit Scotland and the Health and Social Care Alliance, this will require:

- improved funding of community care, including the voluntary sector, to more successfully bridge the gaps between traditional acute and primary care services
- a continued shift in focus towards people, their holistic needs and their experience as they navigate the health and social care system, and a move away from condition-based treatment pathways.

## 2

### **There is a substantial opportunity for commissioners and providers to harness the power of non-clinical support, including the voluntary and community sector (VCS). This will relieve the pressure on the NHS and create better outcomes for people, and improved patient flow within and between health and social care providers.**

We recommend the following options should be explored.

- Supporting change and recovery by having a named non-clinical person to provide support throughout a person's journey through hospital and the return home again, including having them as the critical link with community teams.
- Facilitating more frequent in-person discussions with patients, their families and carers, about their holistic clinical and non-clinical needs, in order to improve patient experience and outcomes.
- Tackling 'initiative fatigue' by providing greater support from the VCS for clinical teams, including for delivering existing good-practice programmes to support recovery, such as Dundee Enhanced Community Support – Acute (DECS-A) (see Appendix).

### 3

## Checking people's ability to live independently as part of the discharging process.

In our report *Home to the unknown: Getting hospital discharge right*, we set out five independence factors that illustrate the importance of considering how the wider context of a person's life – beyond their immediate, clinical needs – needs to be accounted for in planning for their discharge. We recommend that 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:

1. practical independence (e.g. suitable home environment and adaptations)
2. social independence (e.g. risk of loneliness and social isolation; whether they have meaningful connections and support networks)
3. psychological independence (e.g. how they are feeling about going home; dealing with stress associated with injury)
4. physical independence (e.g. washing, getting dressed, making tea) and mobility (e.g. need for a short-term wheelchair loan)
5. financial independence (e.g. ability to cope with financial burdens).

### Leaving hospital:

#### Can this person live independently?

British Red Cross recommends a **five-part independence check** as part of the discharge process – before or within 72 hours of discharge.



**Practical independence** – Can they manage at home? Are there any unmanageable physical obstacles?



**Social independence** – Are they at risk of loneliness? Do they have good social connections and support?



**Psychological independence** – How do they feel about returning home? Are they stressed about living with their illness or injury?



**Physical independence** – Can they look after themselves and their home?



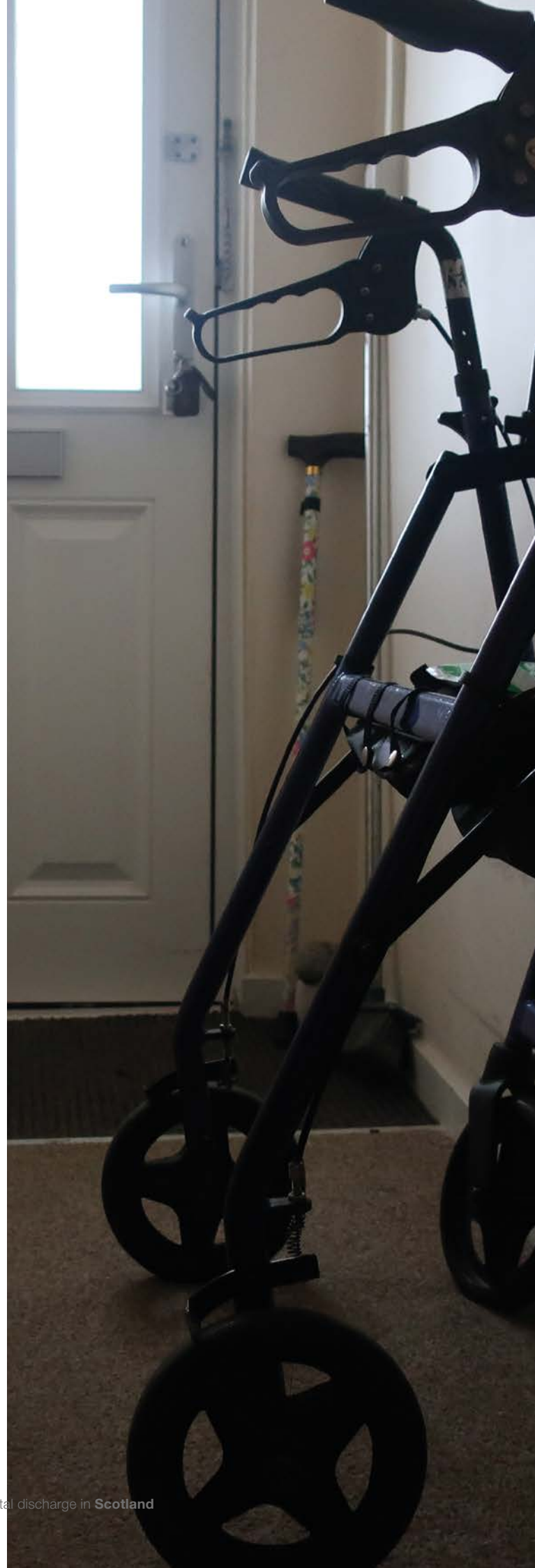
**Financial independence** – Do they have any financial issues as a result of their injury or illness?

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# Conclusion

Unplanned hospital stays are inevitably disruptive to a person's well-being. But the experience someone has during their stay in hospital, the ways they are prepared for discharge and the extent to which the course of their long-term recovery is actively considered in hospital all affect their ability to thrive once they return home.

Our recommendations to improve hospital discharge will require commitment from and collaboration across all those involved in the planning, commissioning and delivery of health and social care in Scotland, including government, health and social care services, and the voluntary and community sector. At the centre of all these changes must be the patients themselves. We would urge professionals and volunteers to consider how each and every conversation with patients and their families can contribute to a positive and successful experience of discharge, identifying the simple ways to build confidence and support recovery following an admission to hospital.



# Appendix

## Dundee Enhanced Community Support – Acute (DECS-A)

In Dundee, the British Red Cross is working with the Dundee Health and Social Care Partnership to support earlier discharges from hospital and to help people resettle in their homes and learn to live with their new health condition. This service provides short-term support (up to 21 days) to people who are leaving hospital and an assessment of their ability to remain at home with support. The British Red Cross team helps transport the person safely to their home and assesses their non-clinical care needs. This allows people to make informed decisions about appropriate long-term care to be taken at home rather than in a hospital setting, and gives reassurance to carers and relatives. The support is highly valued by hospital

staff and service users, who feel better able to live independently in their own homes.

Early evaluation showed that 72 per cent of people who had left hospital and who had been supported by this service were not re-admitted to hospital within six weeks of the evaluation period and were able to live in their homes with personal care support. Forty-five per cent of people were able to stay at home with care support. Fifteen per cent did not require any support at all after this short-term intervention. These evaluation findings highlight that a fairly short-term intervention at the right time can improve patient health and well-being outcomes, while reducing pressure on health and social staff and longer-term costs.



The British Red Cross has been working between home and hospital since before the NHS was established. Today our health and social care services help over 200,000 people across the country continue to live safely and independently. Our services have a simple idea at their heart: preventing health problems from escalating into personal crises.

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