QUICK GUIDE: IMPROVING HOSPITAL DISCHARGE INTO THE CARE SECTOR

TRANSFORMING URGENT AND EMERGENCY CARE SERVICES IN ENGLAND

This is one of a series of quick, online guides produced by NHS England with partners providing practical tips and case studies to support health and care systems.

Click below to view
• Better use of care at home
• Clinical input to care homes
• Identifying local care home placements
• Sharing patient information
• Technology in care homes
INTRODUCTION

This quick, online guide provides ideas and practical tips to commissioners and providers on how to improve hospital discharge for people with care home places or packages of care at home.

A broad range of national and local organisations (including acute trusts, local authorities, independent care sector providers and commissioners) worked together on the development of this Quick Guide to identify existing solutions to common problems that can be implemented quickly ready for winter. The practical tips within this Quick Guide are to be taken as pragmatic recommendations to support local health and care systems; they are not mandatory.

The recommended way to use this quick guide is to convene a local working group of all key stakeholders, including care sector providers, service users, families and carers and to use the contents as a checklist for discussions and to support identification of joint solutions that are right for your locality. Each element of the checklist contains examples of how these issues have been tackled and organisations have kindly shared some of their resources, which are available through the hyperlinks embedded throughout the document.

CULTURE:
Improvement needed in how the care sector, NHS and social care work together.

CHECKLIST ACTIONS FOR LOCAL HEALTH ECONOMIES TO CONSIDER

Has the local system:

1. Arrangements in place for working in partnership and building trust, and physically meeting at least once every year?
2. An understanding of the role and responsibilities of care sector providers, and their existing pressures?
3. Considered pooling resources to optimise services and reduce organisational boundaries?

EXAMPLES OF PRACTICAL SOLUTIONS AND LINKS TO RESOURCES

Local forums to share information, best practice and undertake planning:

- The Norfolk & Norwich University Hospital NHS Foundation Trust runs an Annual Care Provider and Care Home Workshop, usually in November, each year.
- Norfolk Locality Provider Forum meets quarterly with commissioners, and includes residential and nursing homes, domiciliary providers, supported living providers, as well as the voluntary sector and day services.

Royal Berkshire NHS Foundation Trust provides early, informal notification to care homes of residents’ levels of fitness and anticipated discharge date. They work across systems to include care home managers with planning, making them aware of pressures and also making ward teams aware of the constraints felt by care homes.

Hertfordshire Valley - discharge navigators from the Trust have worked with the care improvement team in care homes for a day to understand the different working environment and information needs.

The Calderdale Framework has been used widely to support new ways of working and culture change.
IMPROVING COMMUNICATION

CHECKLIST ACTIONS FOR LOCAL HEALTH ECONOMIES TO CONSIDER

Does the local system have:

4. Local agreement on how care homes and home care providers can be involved early in assessment and discharge planning processes?
5. A single point of access, or named contacts in place?
6. Agreed escalation processes with care sector providers at times of increased pressure?

EXAMPLES OF PRACTICAL SOLUTIONS AND LINKS TO RESOURCES

Whittington Hospital has named points of contact for all of the organisations involved across the geriatric pathway and has strong links with local care homes and home care providers.

Wakefield district’s ‘Connecting Care’ project is developing three integrated hubs, including the care sector, to undertake proactive assessment and review of residents of care homes.

Dorset Healthcare University NHS Foundation Trust has a single point of contact for intermediate care, long term condition and therapy services.

Shrewsbury and Telford Hospital NHS Trust’s Discharge Liaison Team includes care sector providers in MDT meetings and discharge planning.

North Staffordshire has developed a system-wide escalation protocol, which includes care providers, for times of increasing pressure.

CLARITY ON INFORMATION SHARING AND INFORMATION GOVERNANCE

CHECKLIST ACTIONS FOR LOCAL HEALTH ECONOMIES TO CONSIDER

Does the local system have:

7. Joint protocols and documentation for handovers with care sector providers for admission and discharge, including agreement on a secure method of communication?
8. Common documentation for assessment?

EXAMPLES OF PRACTICAL SOLUTIONS AND LINKS TO RESOURCES

Many systems have introduced patient-held information which they can take with them across different health and care settings:

- West Norfolk GPs are currently piloting a ‘green envelope scheme’- all care home residents have an emergency summary care record sealed within a green envelope to be opened by healthcare professionals at a time of emergency;
- West Hampshire uses a transfer of care bag (completed by care homes) for care home residents.

MYTH BUSTER

Patient information can be shared across MDTs. 
Quick Guide: Sharing Patient Information.
Many health economies have established joint protocols and documentation for discharge, for example:

- West Hampshire CCG has produced an inter-health discharge tool;
- University Hospital Coventry and Warwickshire has developed information sharing paperwork with local care homes and home care providers. They use a Client Information Transfer Sheet that is completed over the phone with the care home as evidence that they are still able to meet the patient’s needs - this is kept with the patient’s records at the care home;
- Doncaster Bassetlaw NHS Foundation Trust has local agreement to remove assessment notifications (section 2) and discharge notifications (section 5) for patients being discharged with social care needs without existing social care packages. Ward staff call the health call handling centre with details and a joint case manager is appointed to triage the referral, determine suitability and agree a date and time for discharge within 1 hour. The assessment then takes place at home within 2 hours of the agreed discharge date and time.

DIFFICULTIES WITH ACHIEVING THE ‘HOME BEFORE LUNCH’ AMBITION

CHECKLIST ACTIONS FOR LOCAL HEALTH ECONOMIES TO CONSIDER

Have hospitals put in place arrangements for:

9. ‘To Take Out’ (TTO) medicines ordered and available the day before discharge?
10. A responsive patient transport system, with timeslots available for booking on the day?

EXAMPLES OF PRACTICAL SOLUTIONS AND LINKS TO RESOURCES

Sandwell and West Birmingham Hospitals NHS Foundation Trust include a pharmacist in the daily ward round so that TTOs can be ordered the day before discharge and are ready to go on the morning of discharge. Pharmacists are also included in capacity meetings to identify and quickly deal with any urgent TTOs.

Sheffield Teaching Hospital encourage all doctors to complete TTOs as soon as patients no longer require acute medical care.

University Hospitals Bristol NHS Foundation Trust and North Bristol NHS Trust have developed discharge lounges to mitigate delays with transport and pharmacy.

Yorkshire Ambulance Service NHS Trust has developed a Patient Charter for their patient transport service.
ASSESSMENTS UNDERTAKEN IN HOSPITAL LEADING TO ‘DECONDITIONING’ AND LONGER, UNNECESSARY HOSPITAL STAYS

CHECKLIST ACTIONS FOR LOCAL HEALTH ECONOMIES TO CONSIDER

Has the local system:

11. Considered with all key partners the best possible local arrangements for assessments to take place outside of hospital?
12. The ability to assess people’s long term needs at home, where appropriate?
13. Set a performance standard for assessment outside of hospital?

EXAMPLES OF PRACTICAL SOLUTIONS AND LINKS TO RESOURCES

Many systems have introduced ‘discharge to assess’ (D2A) models of care - where people who are medically fit for discharge are provided with short term support to be discharged to their own home, where assessment is then undertaken by allied health professionals. This model has reduced excess bed stays, increased patient and relative satisfaction, and led to better long term outcomes and less dependency for people.

Some examples of D2A models and links to useful documents providing more information:

- Sheffield Teaching Hospital
- South Gloucestershire and Bristol
- South Warwickshire
- South Warwickshire CCG’s business case to set up a D2A pilot
- Aintree University Hospital NHS Foundation Trust

South Warwickshire has introduced an assessment standard and undertakes internal monitoring against this - ‘no assessment for long term needs should be undertaken in an acute hospital bed unless it is in the patient’s best interests’.

West Cheshire CCG have introduced a CQUIN for discharge to assess.

DELAYS TO DISCHARGE DUE TO AWAITING FOR ASSESSMENT

CHECKLIST ACTIONS FOR LOCAL HEALTH ECONOMIES TO CONSIDER

Has the local system:

14. The ability to undertake assessment and discharge at weekends?
15. Got a shared understanding and agreement on continuing healthcare (CHC) processes?
16. Considered implementing a trusted assessor model or other arrangements for removing delays caused by awaiting assessments?

MYTH BUSTER

CHC assessment doesn’t need to happen in hospital.

Best practice for continuing healthcare can be found here.
EXAMPLES OF PRACTICAL SOLUTIONS AND LINKS TO RESOURCES

Many local health economies have agreed ‘trusted assessor models’ - with one person/team appointed to undertake health and social care assessments on behalf of multiple teams, using agreed criteria and protocols. Some examples of local models that have been adopted:

- University Hospital Coventry and Warwickshire NHS Trust’s Integrated Discharge Team are trusted assessors for all residential and housing with care units in Coventry, and the IDT can also restart packages of social care, if there is no change in people’s needs.
- Medway Community Healthcare staff can restart packages of care if people’s care requirements have not changed.

Wakefield Local Authority has a hospital-based social work team which can discharge within hours of being given relevant information, Monday - Saturday, and Sundays during winter months.

Sandwell and West Birmingham Hospitals NHS Foundation Trust has social worker presence in admission wards to identify people who will require their input.

Wakefield Local Authority contractually requires home care providers to restart packages of care within 24 hours.

The Social Care Institute of Excellence has developed e-learning for the CHC process.

CAPACITY OF COMMUNITY-BASED SERVICES

CHECKLIST ACTIONS FOR LOCAL HEALTH ECONOMIES TO CONSIDER

Does the local system:

17. Have an up-to-date directory of services?
18. Have a system for mapping care home capacity on a daily basis?
19. Have mechanisms for putting in place additional capacity in the care sector at times of pressure?

EXAMPLES OF PRACTICAL SOLUTIONS AND LINKS TO RESOURCES

NHS England has produced a Quick Guide: Identifying local care home placements.

University Hospitals for Coventry and Warwickshire NHS Trust has a brokerage system with care homes which is able to source care provision (including short term provision), and chase and escalate delays.

Medway Community Healthcare’s Integrated Discharge Team can refer people to voluntary sector services (Age UK, Carers First, Red Cross, Medway Care Navigator Service) and telecare/telehealth services, e.g. lifeline and keysafes.

North Hampshire CCG, Southern Health NHS FT and Hampshire County Council are piloting an extended joint discharge project for individuals assessed as requiring input from both health and social care services. When existing community services do not have sufficient resources to meet people’s needs upon discharge, a health and social care package is jointly commissioned from an independent care sector provider, which is then invoiced separately. For example, social care workers are trained to administer PEG feeds, insulin and nebulisers.

Shared Lives is an alternative to home care and care homes - and matches individuals with care needs to family-based home shares.
PATIENT EXPERIENCE AND INVOLVEMENT

CHECKLIST ACTIONS FOR LOCAL HEALTH ECONOMIES TO CONSIDER

Have local systems put in place arrangements for:

20. Clearly communicating with patients and relatives on processes, timescales and setting clear expectations regarding discharge to care sector providers?

21. Understanding people’s experience of discharge to care sector providers?

22. Ensuring that patients and carers are involved directly in assessment and discharge processes?

EXAMPLES OF PRACTICAL SOLUTIONS AND LINKS TO RESOURCES

The Care Act 2014 sets out the duties placed on local health systems, and sections 3 and 7 of the implementation guidance, with respect to providing information to people during transfers of care. Further practical guidance and more detailed support and examples can be found here.

Wirral University Teaching Hospital NHS Foundation Trust’s Integrated Discharge Team is using patient stories as part of their review of patient journeys to identify blockages or missed opportunities for improvement.

West Cheshire CCG has introduced ‘This is Me’ cards to support more personalised transitions for people with dementia.

Lancashire Teaching Hospitals NHS Foundation Trust commission a personalised support service for people being discharged into care homes, supporting them to make choices which has resulted in reducing delayed transfer of care by ten days.

Newcastle upon Tyne NHS Foundation Trust has developed a Choice Policy for when patients need to move out of an acute bed and what happens if their care home of choice is full.
The checklist questions throughout this quick guide have been summarised below:

1. Arrangements in place for working in partnership and building trust, and physically meeting at least once every year?
2. An understanding of the role and responsibilities of care sector providers, and their existing pressures?
3. Considered pooling resources to optimise services and reduce organisational boundaries?
4. Local agreement on how care homes and home care providers can be involved early in assessment and discharge planning processes?
5. A single point of access, or named contacts in place?
6. Agreed escalation processes with care sector providers at times of increased pressure?
7. Joint protocols and documentation for handovers with care sector providers for admission and discharge, including agreement on secure method of communication?
8. Common documentation for assessment?
9. ‘To Take Out’ (TTO) medicines ordered and available the day before discharge?
10. A responsive patient transport system, with timeslots available for booking on the day?
11. Considered with all key partners the best possible local arrangements for assessments to take place outside of hospital?
12. The ability to assess people’s long term needs at home, where appropriate?
13. Set a performance standard for assessment outside of hospital?
14. The ability to undertake assessment and discharge at weekends?
15. Got a shared understanding and agreement on continuing healthcare (CHC) processes?
16. Considered implementing a trusted assessor model or other arrangements for removing delays caused by awaiting assessments?
17. Have an up-to-date directory of services?
18. Have a system for mapping care home capacity on a daily basis?
19. Have mechanisms for putting in place additional capacity in care sector at times of pressure?
20. Clearly communicating with patients and relatives on processes, timescales and setting clear expectations regarding discharge to independent care sector providers?
21. Understanding people’s experience of discharge to care sector providers?
22. Ensuring that patients and carers are involved directly in assessment and discharge processes?
To share or discover more case study examples in this area please use the BetterCareExchange. Create an account here.

Special thanks goes to these organisations for their support, time, effort and commitment during the development of this Quick Guide.

Did you find this Quick Guide useful?  Yes  No