QUICK GUIDE: BETTER USE OF CARE AT HOME

NHS England

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

- Clinical input to care homes
- Identifying local care home placements
- Improving hospital discharge into the care sector
- Sharing patient information
- Technology in care homes

Registered Nursing Home Association

CARE ENGLAND
Representing independent care providers

UKHCA
United Kingdom Home Care Association

INTRODUCTION

Care at home and housing support enables people to live independently and well in their preferred environment for longer, providing continuity and familiarity through frequent close contact. It plays an essential role in helping people return home, which should always be seen as the default option. This quick guide provides case studies, ideas and practical tips to commissioners, health professionals and care providers on how to improve the relationships, processes and use of homecare and housing support to help people home from hospital.

Waiting for homecare is now the most common social care related reason for delayed transfer of care (18% of total).

104% rise in 15 months - number of excess bed days from awaiting care at home.

People were kept in hospital for 255,000 days in twelve months to September '15 due to a lack of homecare.

90% of older people live in ordinary housing (6% in specialist housing, 4% in care homes).

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A group of key organisations involved in homecare, housing and adaptations provision, health and commissioning - at both a local and national level - worked together on the development of this quick guide, which encompasses services paid for privately in addition to those funded by the state. It identifies common problems experienced and highlights good solutions which are already being implemented, that can be instigated quickly and effectively.

This quick guide will focus on three elements of a patient's pathway:

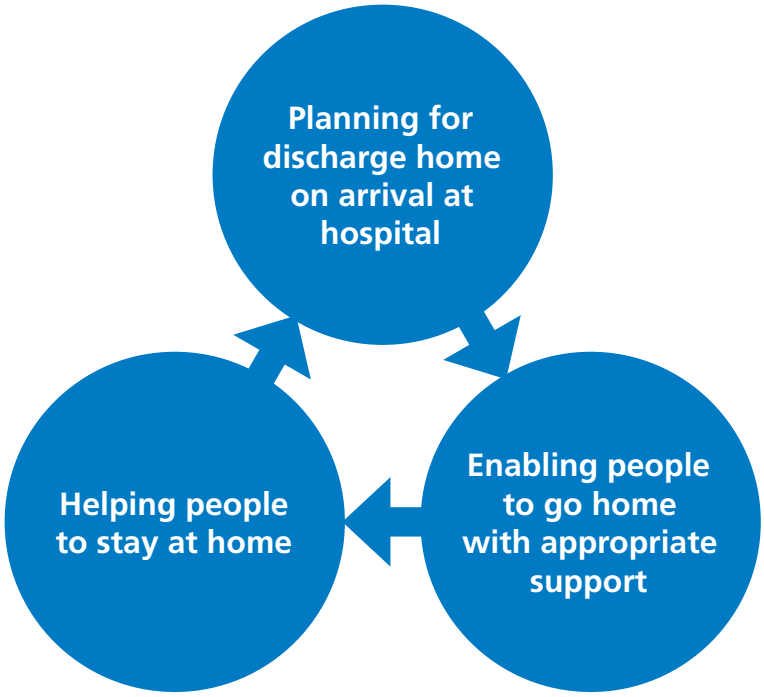
1) Planning for discharge home on arrival at hospital;
2) Enabling people to go home with appropriate support;
3) Helping people to stay at home.

The recent NICE Guideline Homecare: delivering personal care and practical support to older people living in their own homes provides the principles and recommendations for high quality homecare. It includes recommendations on:

- Ensuring care is person centred;
- Providing information about care and support options;
- Planning and reviewing homecare and support;
- Delivering homecare;
- Joint working between health and social care;
- Ensuring safety and safeguarding people using homecare services;
- Recruiting, training and supporting homecare workers.

The practical tips included in this quick guide have been developed by a broad stakeholder group and are to be taken as pragmatic recommendations to support local health, housing and social care systems; they are not mandatory. For more information on the ideas or examples found in this quick guide, please contact Dominic.Carter@UKHCA.co.uk.

1 http://www.england.nhs.uk/statistics/statistical-work-areas/delayed-transfers-of-care/



CARE AT HOME MIGHT INCLUDE:

- Homecare by the hour
- Live-in, 24hr homecare
- Extra care or supported living housing
- Housing support
- Adaptations to the home
- Telecare or telehealth

MYTH BUSTER

What care at home can provide for individuals:

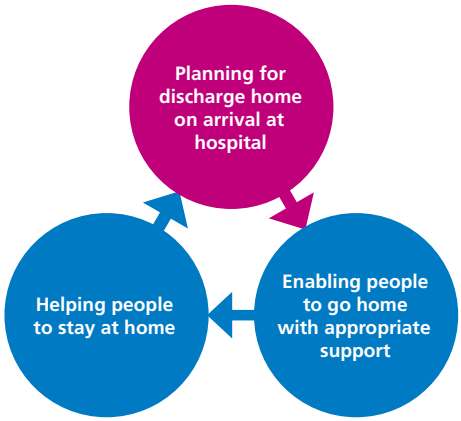
CARE AT HOME CAN...

- Be well placed to know the individual, their ambitions, home circumstances and care history;
- Be a highly skilled and important part of a qualified, multi-disciplinary team;
- Be an asset in every part of the patient journey, from information at admission, providing continuity of care during their stay and helping them back home, to settle and then stay there;
- Enable safer, more independent living, supported by adaptations;
- Be provided in a range of familiar settings, day or night.

CARE AT HOME CANNOT...

- Create significant immediate capacity. Time is needed to recruit staff and put rotas into place;
- Operate to full potential without being informed, through a named contact, about the individual they are expected to support;
- Help to reduce delayed discharges without being included in the wider care of the individual;
- Provide care in an unsafe, unsuitable home environment.

PLANNING FOR DISCHARGE HOME ON ARRIVAL AT HOSPITAL



PRACTICAL TIPS

1. Informing and empowering patients as early as possible

- Ensure people who are in hospital have access to the information and choices available to help make good decisions around discharge, including information about housing options. This information may be available from homecare or housing providers as well as family members or health professionals;
- Consider, with consent, sending a copy of the discharge letter to the homecare or housing provider as a key partner;
- Collaborate with local authorities and voluntary agencies to provide hospital discharge written information / brochure / national website details;
- Empower the individual to make personalised choices around discharge, including the environment where they wish to be discharged to.

HELPFUL EXAMPLES

Bluebird Care & Everylife Technologies

Age UK Norfolk - Information and advice hospital based service

Care Act 2014 Statutory Guidance on information sharing and advocacy (see Sections 3 & 7)

2gether NHS Trust - Implementation of Direction on Choice of Accommodation

Free DCLG backed advice service

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2. Set expectations about discharge on admission to hospital

- Use the admission assessment as a tool to begin these conversations and include:
  - Likely date for discharge;
  - If a care package is in place already, ensure the homecare provider is telephoned about the admission and likely discharge date;
  - Explanation of any re-assessment process during the hospital stay and whether the home is a safe and suitable place to which patient can be discharged;
  - If there are likely to be any capacity issues under the Mental Capacity Act that will affect discharge;
  - Where a person has 'around the clock care', like 'live-in', consider how the carer can support this person whilst in hospital, especially if they have a dementia diagnosis;
  - Be aware if there is a Health and Welfare Power of Attorney and / or an Advanced Care Plan.
- Design written information about discharge in collaboration with commissioners and care providers;
- Write in plain English;
- Involve Occupational Therapy at an early stage to assess physical function and housing suitability.

HELPFUL EXAMPLES

2gether NHS Foundation Trust - Goal Oriented Admission

2gether Trust - Re-defined Acute Care Pathway

3. Involve those who know the person best in early discharge planning

- This obviously includes, wherever possible and appropriate, relatives, family carers and next-of-kin, but may also include care or housing professionals who know the person well;
- Recognise and include homecare and housing providers as skilled partners in the care team in appropriate multi-disciplinary discussions at an early stage. This will ensure that any necessary changes in the care package can be planned and the package is ready-to-go when required;
- Acute trusts and social services should meet to agree how care planning can enhance communication and relationships between all involved in discharging a person who is in hospital;
- Every homecare and housing provider should have a named point of contact in the local social services department and acute trust to enable relationship-building and smooth communication;
- If practically possible, co-locate health and social care workers to further improve effectiveness.

HELPFUL EXAMPLES

West of England Care & Repair caseworker is member of an Integrated Discharge Hub

Housing LIN - Health and Housing

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4. Create ways to improve relationship and communications between health and social care professionals and simplify the discharge process

- If not already in place, Trusts should consider hospital-based social worker, social care lead or independent care sector discharge co-ordinator roles. A coordinator:
  - may need to have links with a number of different local authorities;
  - could coordinate the discharge process;
  - can improve relationships and communication between health, social care and housing;
  - should be well informed of the variety of local homecare, housing and adaptation provision and have knowledge about accessing all funding streams, for example Personal Budgets and Continuing Health Care funding;
  - will also need to be aware of who is paying for the package of care at home, and who has commissioned it;
- Homecare and housing providers are ideally placed to flag any instances of family carers being admitted to hospital that may leave someone vulnerable and in need of additional support in the community;
- Acute Trusts and social services, in conjunction with homecare, housing providers and services that support people to be discharged home, could run 'As is' workshops to review all pathways for admission and discharge;
- Once all pathways for discharge are known, the number of pathways could be reviewed with a view to reducing or simplifying them.

HELPFUL EXAMPLES

Leicestershire NHS Trust reduction in discharge pathways

Hospital2Home includes examples and models - essential information to support hospital discharge

Memorandum of understanding to support joint action on improving health through the home

See the London example included in Quick Guide: Technology in Care Homes

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5. Care at home has a role in flagging those at risk of readmission

- Providers of homecare and housing should be given clear information about those at risk of repeated admission (e.g. UTI or falls) and who the correct person to contact is for advice about the person's health or to flag the need for step-up care.

ENABLING PEOPLE TO GO HOME WITH APPROPRIATE SUPPORT

PRACTICAL TIPS

1. Review and assess baseline and contingency homecare capacity

- Local authority and Continuing Health Care (CCGs) commissioners need to be in regular contact, and work closely with, all local homecare and housing providers (e.g. extra sheltered care and housing with support) to identify baseline and contingency capacity;
- Local authority commissioners could investigate local capacity mapping exercises in the lead up to winter, which can help commissioners understand the hours of provision available for hourly, live-in and nursing care at home, housing / housing-with-care providers, and the extra capacity that could be available across all local providers;
- Local commissioners should work in partnership with care at home partners to ensure capacity is in place when required;
- Conversations around cold weather planning should occur in a timely fashion - this might include block booking hours of care at home up to 3 months in advance, giving providers the opportunity to carry out staff recruitment and create capacity;
- Involve housing and housing service providers in system planning;
- The Cold Weather Plan for 2015/16 is a key component of emergency planning and provides advice for all potential partners, in addition to people living at home;
- It is advisable for the provision of housing and adaptation services to be reviewed, in the lead up to winter, to ensure there is enough capacity to fast-track housing support services to enable rapid discharge from acute trusts and/or step-down and intermediate care beds.

HELPFUL EXAMPLES

East Devon pre-booking of homecare services

Cambridge pre-booking of homecare services

Bluebird Care & Peterborough City Hospital - Joint Emergency Team

South Gloucestershire and Bristol Discharge to Assess model

Public Health England - The Cold Weather Plan 2015/16

The Good Care Group - Living Well at Home in Winter

Middlesbrough Staying Put Hospital Discharge Service

Extra Care Housing as another option - Housing LIN

Hertfordshire Enhanced Homecare Project

Practical examples of the contribution of housing associations can be found in 'On the pulse'

2. Inform homecare and housing providers as soon as possible about discharge arrangements

- In order to start or re-start care packages quickly, homecare and housing providers (existing or new) should be informed as soon as possible of the planned date and time of discharge;
- As partners in the care team, homecare, housing providers, acute Trusts, community services and social services should be in regular contact to agree what information is required, the format and process for receiving (i.e. timescales and method);
- The discharge process should include agreements on how to manage the flow of information between all relevant parties;
- Any changes to the time of discharge or condition of the individual should be communicated with as much warning as possible;
- Local providers should work together to ensure these communication routes are in place;
- Ensure hospital notes state whether homecare providers have 'authorisation relating to confidential information' to ensure constructive and speedy dialogue. Please refer to the Quick Guide: Sharing Patient Information for further guidance.

HELPFUL EXAMPLES

Age UK and South Warwickshire Primary Care Navigator Pilot

Bluebird Care and Peterborough City Hospital

Quick Guide: Sharing Patient Information

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3. Where appropriate continue or quickly restart current package of care on discharge

- Stability and continuity of care, and familiarity of those providing care, can lead to a quicker discharge, particularly for people living with dementia;
- If an individual already has a care package in place at home, and is happy with their current provision, their care package should be restarted immediately on discharge, to ensure continuity of care;
- Commissioners may wish to consider the benefits in continuing to provide social care support within the hospital setting to maintain trusted relationships and help providers gauge and support any change in condition. This is particularly important when a person has complex needs such as dementia or Parkinson's.

HELPFUL EXAMPLES

The Good Care Group

4. Use discharge to assess processes when and if appropriate

- Local health, social care and housing commissioners and providers may wish to consider the implementation of discharge to assess models. This is when assessment for longer-term care needs, housing related interventions and continuing healthcare are performed in a person's home rather than in an acute setting, potentially with the help of the care provider;
- This model can help to 'optimise' the individual and improve the accuracy of the assessment outcome. If there is a housing suitability issue (e.g. need for home adaptations or to move house) it may be that temporary accommodation or step-down facilities are the most suitable environment for this assessment;
- Commissioners should consider discharge pathways in place for people who are homeless or have no suitable place to recover well;
- Local authorities, CCGs and housing support agencies need to work together to ensure these pathways are clear and robust.

HELPFUL EXAMPLES

Bradford Respite and Integrated Care and Support Service (BRICSS)

Calderdale Housing Scheme

Hertfordshire County Council - cognitive enablement at home project

Brighton University Hospital Discharge to Assess Model

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5. Be creative with transport home options

- Local health and social care commissioners may wish to consider homecare providers arranging collection from hospital and settle services for people not requiring specialist transport. This could also decrease the need for hospital transport during pressured periods, as well as improving the patient experience of discharge;
- Some voluntary services provide a 'home from hospital' service which could work with ongoing homecare for the individual;
- Local authority and health commissioners should work with local voluntary organisations and homecare providers in order to identify, sign-post and commission these services.

HELPFUL EXAMPLES

Home and Settle Services - supporting discharge from hospital to home:

- British Red Cross
- Royal Voluntary Service

Manchester Care & Repair Service

6. Local health and social care economies should consider together the availability and capacity of home improvement, repair and adaptations services, fast-track schemes, suitability of housing and telecare

- Safe and suitable housing is essential for people to be able to remain independent at home;
- Local housing support, housing adaptation and improvement services should be made readily available and easily accessible to discharge planners in the acute setting, and training should be provided to the relevant staff on the options available;
- Check whether your area has a 'Housing & Care options advice service';
- Commissioners could look to housing and home improvement agencies or consortia and ask for proposals to enhance hospital discharge support;
- Commissioners (CCGs and Local Authorities) should be familiar with systems of provision of help with home adaptations;
- Local commissioners may want to consider:
  - Integrated provision of home adaptations, including fast tracking for hospital discharge;
  - A pooled budget provision of home adaptations.

HELPFUL EXAMPLES

Manchester Care and Repair

Care & Repair England with Public Health England

WE Care and Repair

Middlesbrough Home adaptations for disabled people

Ealing Home adaptations for disabled people

Wigan Home adaptations for disabled people

Housing & Care options advice service

Housing LIN - Telecare

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7. Make best use of reablement and rehabilitation services

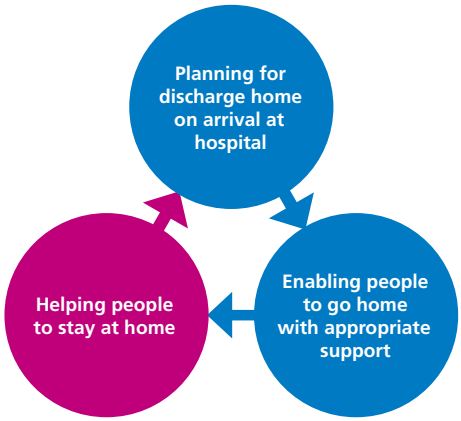
- Needs to be goal-oriented and can be provided in a number of housing settings, which may be an interim arrangement;
- Reablement is a flexible and valuable service, but should not be seen as a default option, nor as a standardised period of 6 weeks;
- Reablement should not be considered to automatically supersede a package of care at home which is already meeting the needs of the individual;
- In many cases, reablement will be best suited to working in partnership with care at home.

HELPFUL EXAMPLES

The Good Care Group - Rehabilitation

Calderdale housing scheme

HELPING PEOPLE TO STAY AT HOME SAFELY



PRACTICAL TIPS

1. Share information safely, quickly and easily

- Multi-disciplinary teams across health, social care and housing should be enabled to share information regarding direct care as easily and quickly as possible;
- Check that policies, processes and systems for sharing information about individuals are fit for purpose and do not create unnecessary barriers for sharing information.

HELPFUL EXAMPLES

Bluebird Care & Peterborough City Hospital

Quick Guide: Sharing Patient Information

Sending Secure email

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2. Arrange a swift follow up call / visit following discharge

- Following discharge, people should be followed up quickly by an appropriate member of their health team - this could be a community matron, a GP, a community or acute therapist;
- There is a possible need for further follow up (to happen in a co-ordinated way) if a range of care, support, housing modifications or assistive technology are seen as necessary to help the person maintain their health, independence and wellbeing, including connecting people with community resources (i.e. not just services);
- Consider pursuing Virtual Ward models, increasing the amount of care delivered within the community. Include homecare and housing providers as part of the Virtual Ward multi-disciplinary team. The local acute Trust, social services, community services, housing providers and commissioners need to be involved in the implementation of a virtual ward;
- Agree whether the virtual ward will be for step-down, step-up or both.

HELPFUL EXAMPLES

Derby Teaching Hospitals Virtual Ward model

2gether Trust - Procedure for discharge including 48 hour follow up

Age UK Norfolk - GP info and advice service

3. Agree a joint care and support plan and identify a link / coordinator

- As partners in care, multi-disciplinary teams should include homecare and housing providers. The NICE Guideline Homecare: delivering personal care and practical support to older people living in their own homes (1.3.24) recommends all involved in providing care and support should have access to any homecare plan and 'care diary/record' (a detailed day-to-day log of all care and support provided);
- Multi-disciplinary teams should agree a joint care plan, with one member agreeing to be overall link coordinator;
- Consider housing agencies working with therapists and case workers in the MDT;
- Electronic records sharing initiatives, such as 'Coordinate my Care', allows people (together with their GP or other clinician) to create a personalised urgent care plan. In the plan they can record their views and wishes about their future care, what they would like to happen, where they want to receive care, and even things they would like to avoid (like admission to hospital). This ensures everyone caring for a person - including social care and urgent and emergency care services - know about their preferences.

HELPFUL EXAMPLES

NICE Guideline Homecare: delivering personal care and practical support to older people living in their own homes

Coordinate my care

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4. Review care packages regularly

- Multi-disciplinary teams across health and social care who are caring for a person, should build in review stages as part of the joint care planning process. This review should include suitability of the home;
- This will ensure people get the right level of care and support at any one time;
- Care packages must reflect these reviews, with step-up and step-down arrangements put in place, as necessary, to avoid hospital (re)admission.

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5. Recognise the value of continuity in care relationships

- Continuity of care workers is really important for people receiving care in their own homes;
- This enables people to build relationships with their care worker, enabling changes in support needs to be recognised more quickly;
- Identified changes in need should be recognised by health and care commissioners.

6. Use what resources are already accessible and know what is available

- People should be referred or sign-posted to the appropriate local community resources available as their needs change, including housing improvement services;
- Multi-disciplinary teams across health and social care should have access to local community service information, including housing related services;
- There is a free advice line/website about housing and care options plus links to local providers available;
- The Care Act places a duty on local authorities to provide local information and advice.

HELPFUL EXAMPLES

NHS Choices also has lots of information about community services

Free advice line / website about housing and care options

The Housing LIN has a specific section for health and social care commissioners and providers on Care and Support at Home

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7. Expand the role of homecare provision in end-of-life care pathways

- Recognise and consider homecare providers when reviewing end-of-life pathways locally;
- This will help to ensure that timely support is available throughout end-of-life pathways;
- Modifications to the home can help to facilitate end-of-life care at home;
- Round-the-clock care can be delivered by live-in care providers enabling people to exercise their choice to die at home;
- Electronic Palliative Care Co-ordination Systems (EPaCCS) enable the recording and sharing of people's care preferences and key details about their care at the end-of-life. Further support on implementing or planning local EPaCCS is available here.

HELPFUL EXAMPLES

End-of-life best practice:

- The Good Death Project
- The Good Care Group - Discharge and end of life care at home

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

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