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QUICK GUIDE: SUPPORTING PATIENTS' CHOICES TO AVOID LONG HOSPITAL STAYS

TRANSFORMING URGENT AND EMERGENCY CARE SERVICES IN ENGLAND

This is one of a series of quick, online guides providing practical tips and case studies to support health and care systems.

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INTRODUCTION

This quick guide aims to support local health and social care systems to reduce the time people spend in hospital, when they are ready to depart and no longer need acute care, but are delayed whilst making decisions about or making arrangements for their ongoing care. This should be read alongside the 2015 NICE guidance 'Transition between inpatient hospital settings and community or care home settings for adults with social care needs'.

People's physical and mental ability and independence can decline if they are spending time in a hospital bed unnecessarily, and they are also at risk of acquiring hospital acquired infections. For people aged 80 years and over, 10 days spent in a hospital bed equates to 10 years of muscle wasting. Severely ill patients may be unable to access services, if hospital beds are occupied with patients whose care can be safely managed in another place.

Ideally, people should make decisions about their long-term care outside of hospital, either in their own home or in an interim bed, where further recovery and assessments can happen in a way that their true long term needs are understood.

This guide has been produced by stakeholders [including hospital discharge teams; local authority adult services commissioners; continuing healthcare commissioners; independent care sector providers, including voluntary and housing sectors; patients; and carers] and provides:

- A checklist for local areas to use to identify areas for improvement;
- Information on existing solutions to common problems, including links to useful resources;
- A template policy and template patient letters to be adopted locally.

JACKIE'S EXPERIENCE OF HER FATHER:

"Staff on the ward are really supportive but the process of discharge is confusing at best and damaging to wellbeing at worst. It's the communication and expectations that is very hard to keep track of: decisions reversed with no notice, no clear guidance to the family of who makes the decision. As we thought he was going into a community hospital we were advised not to go looking at nursing homes again. Getting into the right one is really critical to his wellbeing from here and so now we are ringing around. I'm self-employed so I'm fortunate in having the ability to control my time however I would have really valued having access to a member of the medical team to be able to talk to / email with so not to be losing work as well." (Patient story from Healthwatch England work on hospital discharge).

PATIENT INFORMATION REGARDING CHOICES

CHECKLIST ACTIONS

1. Is relevant information and discussions about choices after discharge consistently brought to people's attention and discussed with them promptly upon admission to hospital?
2. Are information packs available for patients that have been agreed by local health and social care organisations?
3. Have information packs been reviewed for quality by local patients, voluntary groups and/or local Healthwatch?
4. Is information tailored for individuals and their specific needs?
5. Is there equality in the information and support given to all patients, regardless of how their post-hospital care will be funded?
6. Is cost information included to support decisions to be made?
7. Are all staff aware of their role in communicating effectively the expectations regarding the discharge process, in conversations with patients?

EXAMPLES OF PRACTICAL SOLUTIONS AND LINKS TO RESOURCES

Template letters and factsheets are available in Appendix D of the template policy document for organisations to adapt and implement locally - these are to be used throughout the discharge planning process and provide clarity on the choice policy and process to be followed if people refuse to leave hospital. Behavioural insights research tells us that letters have more impact if they are personally addressed (avoiding the use of stickers where possible) and signed by someone meaningful and influential in the patient's care, e.g. their consultant or if that is not logistically possible then the lead consultant for that specialty.

There are a number of national and local resources available to support patients with making choices, for example:

NHS Choices website has an online search function for care homes, housing and care at home service and providers.

Skills for Care has produced useful information and advice on understanding the Care Act 2014, in particular the Financial Information and Advice Handout.

Age UK factsheets to help explain how processes work, entitlements and things to consider in making decisions:

- Care homes
- NHS Continuing healthcare
- Finding help at home
- Hospital discharge arrangements
- Care home checklist
- Paying for permanent residential care
- Paying for care and support at home
- Understanding the Care Act
- Disability equipment and home adaptations
- Funding for home improvements
- Council and housing association housing

"My father-in-law was declared medically fit after about 4 weeks in hospital, but then was not discharged until a total of 10 weeks. The family would have much preferred that he could have been moved closer to home, but very little information was shared with us throughout the entire hospital stay."

First Stop provides a free advice service for people on housing and care options (telephone, website and through local partners). Its website includes a range of useful factsheets and a home from hospital toolkit).

Staffordshire Cares supports people to make informed decisions about the care and support they may require, encouraging self care wherever possible.

Carers UK provides advice and information to people who are carers or considering becoming carers on managing hospital discharge and Carer's Assessments.

Macmillan Cancer Support's Going Home from Hospital Pack.

Poole Hospital NHS Foundation Trust has initiated a 2016 New Year Resolution entitled 'There's no place like home'. This innovative campaign is designed to help raise awareness and understanding within the local system that discharge is as much of an urgent acute issue as admission. It focusses on helping patients return into the community at the point that they no longer need to receive care within a hospital setting. This integrates the local system into creating sustainable and effective improvements over the course of the year which will benefit patients and their families and carers.

SUPPORT TO PATIENTS TO MAKE INFORMED CHOICES

CHECKLIST ACTIONS

8. How promptly are patients, who are likely to require a complex discharge, allocated a discharge coordinator in hospital?
9. Is there a dedicated and unbiased support service to work with patients and/or their representatives in making choices?
10. Does the support service have a focus on getting people back to their home, where possible and where the patient wants this?
11. Have local voluntary sector organisations been involved in designing and delivering support services?
12. Are patients and/or their representatives informed about their rights and where they can find additional support if they are unhappy with the support received or the choices that are available to them?
13. Are there clear processes in place to support people who do not have capacity to make independent decisions about their care, or who need additional support to be fully involved?
14. Are there clear processes for identifying and supporting carers?
15. Is an Electronic Palliative Care Co-ordinated System in place to capture preferences of people at the end of life?

EXAMPLES OF PRACTICAL SOLUTIONS AND LINKS TO RESOURCES

University Hospital of South Manchester NHS Foundation Trust employ two full-time 'homefinders' whose role is to support patients to identify appropriate care and housing upon discharge.

Lancashire Teaching Hospitals NHS Foundation Trust commissions a personalised support service for people being discharged into care homes, supporting them to make choices, which has resulted in reducing delayed days from 16.2 to 5 days (over 5200 in the first year of the scheme).

Care and Repair England have set up the Silverlink initiative developing peer to peer support networks to support people to make more informed choices where people who have been in the same situation can support people to make choices. Information on how you can set this up locally can be found here.

Age UK Norfolk has been working with Norfolk and Norwich University Hospital to provide information and support to people to return home after discharge.

Care and Repair England's project 'If only I had known...' shows how local projects have worked with hospitals to integrate advice on housing within discharge processes and evaluated the impact.

Hospital LIN's 'Hospital 2 Home' resource pack contains tailored information for healthcare professionals on supporting people to return to home.

Pathway has published research and support materials on improving hospital discharge for homeless people.

Staffordshire's Ask Sara website supports people to identify technology to help rebuild and maintain independent living.

Carers UK has an adviceline for carers supporting their loved one out of hospital as well as information on supportive technology to enable independent living.

More information on advocacy can be found here, and on formal advocacy specified by the Care Act here.

Public Health England has resources on how to implement the Electronic Palliative Care Co-ordinated System (EPaCCS), the system requirements and benefits of doing this.

> "It would have been very simple for someone to sit down and explain the diagnosis instead of just saying "Sorry, he has dementia" and walking away. No one understood what this meant for him now and for his future, and it was very difficult to make decisions regarding care after hospital without really understanding what is likely to happen in the next months."

AVAILABILITY OF PROVISION (CARE HOMES AND CARE PACKAGES AT HOME)

CHECKLIST ACTIONS

16. Has the locality completed capacity and demand mapping to ensure there is enough provision to discharge people in a timely manner, including discharge for ongoing assessment?
17. Are there joint plans locally to resolve any capacity issues?
18. Are CCGs working together with local authorities to support them in their statutory duty in shaping the care market?
19. Has work been done to ensure the balance of rehabilitation in care homes versus in the community is appropriate?
20. Are alternatives / more creative options available to people about how they could get 24hr care at home?
21. Are there robust fast-track pathways in place for people at end-of-life?

EXAMPLES OF PRACTICAL SOLUTIONS AND LINKS TO RESOURCES

The Care Act 2014 introduced a duty for Local Authorities to shape the local care market. More information can be found here, including factsheets on market shaping and Deferred Payment Agreements.

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.

Home Improvement Agencies provide repairs, improvements and adaptations services for older and disabled people many of which work closely with the NHS to enable people to leave hospital as soon as they are ready by helping to make their home suitable, warm and adapted with help with equipment and adaptations and with handypersons to do small jobs. Examples are:

- Wigan Council
- Middlesbrough Council
- Manchester Care and Repair
- Care and Repair West England

AT dementia provides information on assistive technology that can help people with dementia live more independently.

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

> "I am disabled, using a powered wheelchair out of doors. My house is adapted for safe walking and I have an electric bed and shower on the ground floor. I use my DLA to pay for help. At home I can organise my life and my own drug regime. Friends can call in easily."

Windsor, Ascot and Maidenhead CCG have developed a 'dashboard' to measure hospital stays, ambulance call outs, and the key medical reasons for hospital admissions. Over time, trend data has helped facilitate transfer of care and better shape the needs of patient's care at home.

Blackpool Teaching Hospitals Foundation NHS Trust has a rapid discharge pathway for end of life patients to be discharged home with all equipment and services in place.

REFUSAL TO LEAVE HOSPITAL

CHECKLIST ACTIONS

22. Do you have a robust policy on managing choice at discharge that provides clarity on legal issues and has been signed off by the executive teams of all local partners?
23. Do you provide training to all staff on implementing the choice policy?
24. Is effective, senior level support provided in managing escalated delayed discharges?
25. Do you provide upfront and ongoing communication to people regarding what the hospital policy is?
26. Does the hospital executive team monitor implementation of the policy?

EXAMPLES OF PRACTICAL SOLUTIONS AND LINKS TO RESOURCES

A template policy 'supporting patients' choices to avoid long hospital stays' is available for organisations to adopt and implement locally. This policy is based on those used in Dorset and Surrey, and contains a process for escalation when people refuse to leave, including specific timescales.

The policy contains template factsheets and letters for organisations to adapt and implement locally - these can be used throughout the discharge planning process. This includes clarity on steps that can be followed if people refuse to leave hospital.

NHS Protect has issued guidance for NHS Trusts on how to enact the Criminal Justice and Immigration Act 2008 (ss119-121) in cases where the patient's refusal to leave hospital when medically fit for discharge constitutes a nuisance or disturbance and there is a power to remove the patient.

USE OF INTERIM PACKAGES / PLACEMENTS

CHECKLIST ACTIONS

27. Do you have joint arrangements for interim packages / placements?
28. Do you have local agreement on funding for interim packages / placements?
29. Do you have clear timescales for the length of time that interim packages / placements will be funded for?
30. Are there arrangements in place to ensure that the majority of continuing healthcare assessments are carried out in interim packages / placements after discharge from hospital?
31. Are people offered a choice of interim placements / packages?
32. Do you ensure that interim placements are not too far away from a person's home that it restricts their family from visiting?

EXAMPLES OF PRACTICAL SOLUTIONS AND LINKS TO RESOURCES

More information on discharge to assess schemes can be found in the Quick Guide: Improving hospital discharge to the care sector - this includes models from South Gloucestershire, South Warwickshire and Aintree, an example business case, and an example CQUIN.

Derbyshire Community Health Services NHS Foundation Trust provides a virtual ward to patients in their homes.

University Hospitals of South Manchester NHS Foundation Trust funds interim placements, with agreement with partners on how assessment capacity will expand to cover people in extra beds unless they have gone there with the assessment already complete and a plan for exit once the resource is available.

Suite of guidance setting out the principles and processes of the National Framework for NHS continuing healthcare and NHS funded nursing care.

Any interim placements will need to use the risk assessment process to determine if the placement is close enough to allow visits from relatives - variables to consider will include how often the relatives usually visit, whether they drive, whether they are financially independent. Where choice of interim placements are limited, there are examples of local areas paying for transport for relatives to visit if they are too far away and there is no easy way of getting there.

"My mother wanted to get out of hospital asap - ideally to get home but a 'half-way house' arrangement whilst all her assessments were being done and her care package arranged would have been so much nicer than a bed on the ward - a sort of 'care hotel' would have been great - she just needed a bit of care, support and reassurance but without the hustle & noise of the ward where, once she was on the road to recovery she was largely just left on her own."

CHECKLIST SUMMARY

THE CHECKLIST QUESTIONS THROUGHOUT THIS QUICK GUIDE HAVE BEEN SUMMARISED BELOW:

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6. Is cost information included to support decisions to be made?
7. Are all staff aware of their role in communicating effectively the expectations regarding the discharge process, in conversations with patients?
8. How promptly are patients, who are likely to require a complex discharge, allocated a discharge coordinator in hospital?
9. Is there a dedicated and unbiased support service to work with patients and/or their representatives in making choices?
10. Does the support service have a focus on getting people back to their home, where possible and where the patient wants this?
11. Have local voluntary sector organisations been involved in designing and delivering support services?
12. Are patients and/or their representatives informed about their rights and where they can find additional support if they are unhappy with the support received or the choices that are available to them?
13. Are there clear processes in place to support people who do not have capacity to make independent decisions about their care, or who need additional support to be fully involved?
14. Are there clear processes for identifying and supporting carers?
15. Is an interoperable Electronic Palliative Care Co-ordinated System in place to capture preferences of people at the end of life?
16. Has the locality completed capacity and demand mapping to ensure there is enough provision to discharge people in a timely manner, including discharge for ongoing assessment?
17. Are there joint plans locally to resolve any capacity issues?
18. Are CCGs working together with local authorities to support them in their statutory duty in shaping the care market?

19. Has work been done to ensure the balance of rehabilitation in care homes versus in the community is appropriate?

20. Are alternatives / more creative options available to people about how they could get 24hr care at home?

21. Are there robust fast-track pathways in place for people at end-of-life?

22. Do you have a robust policy on managing choice at discharge that provides clarity on legalities and has been signed off by the executive teams of all local partners?

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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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