RA790

Department of Health

Discharge from hospital: pathway, process and practice

READER INFORMATION

Policy HR/Workforce Management Planning Clinical	Estates Performance IM & T Finance Partnership Working
Document Purpose	Best Practice Guidance
ROCR Ref:	**Gateway Ref:** 1074
Title	Discharge from hospital: pathway, process and practice
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Target Audience	PCT CEs, NHS Trusts CEs, StHAs CEs, Care Trusts CEs, Medical Directors, Directors of PH, Direc of Nursing, PCT PEC Chairs, NHS Trust Boar Chairs, SHA CEs, Allied Health Professionals, Communications Leads, Emergency Care Le
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Action required	Incorporate into discharge planning process
Timing	**Immediate effect**
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Discharge from Hospital
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Contents

Foreword

Admission to and discharge from hospital can be a distressing time for individuals, their families and friends. For most people, however, treatment will be successful and they will return to their usual way of life very quickly through the provision of an accurate diagnosis, treatment and rehabilitative service. Some people will need additional help to enable them to do so over and above their medical treatment. These needs can be many and varied and cannot be met by the NHS alone.

It is increasingly evident that effective hospital discharges can only be achieved when there is good joint working between the NHS, local authorities, housing organisations, primary care and the independent and voluntary sectors in the commissioning and delivery of services including a clear understanding of respective services. Without this the diverse needs of local communities and individuals cannot be met.

Government policy and recent legislative changes aim to help you work more creatively across the traditional organisational boundaries. I have been impressed by the enthusiasm and commitment to achieve real improved outcomes for people and of the better use of resources that is taking place throughout England. This workbook, primarily concerned with the care of adults with physical ill health, has drawn together some of those examples of good practice to assist commissioners, practitioners and managers in their efforts to improve the processes of discharge planning. It recognises the importance of close working between specialist mental health and learning disability services, and that many of the principles and practices will apply equally to younger adults and children, although further guidance on these will be issued separately.

The key messages contained in this publication are:

- Understand your local community and balance the range of services to meet health, housing and social care needs.
- Ensure individuals and their carers are actively engaged in the planning and delivery of their care.
- Recognise the important role carers play and their own right for assessment and support.
- Ensure effective communication between primary, secondary and social care to ensure that prior to admission and on admission each individual receives the care and treatment they need.
- Agree, operate and performance manage a joint discharge policy that facilitates effective multidisciplinary working at ward level and between organisations.

- On admission, identify those individuals who may have additional health, social and/or housing needs to be met before they can leave hospital and target them for extra support.
- At ward level, identify and train individuals who can take on the role of care co-ordination in support of the multidisciplinary team and individual patients and their carers.
- Consider how an integrated discharge planning team can be developed to provide specialist discharge planning support to the patient and multidisciplinary team.
- Ensure all patients are assessed for a period of rehabilitation before any permanent decisions on care options are made.
- Ensure that the funding decisions for NHS continuing care and care home placement are made in a way that does not delay someone's discharge.

The workbook provides you with guidance and practical tools in a way that allows you to focus on those areas that are presenting you with challenges at a local level. It also directs you to other sources of information and websites where you can obtain useful advice that will help you achieve improved outcomes for individuals and meet performance targets.

Jacquie Smith

Jacqui Smith

Minister of State for health, social care, long-term care,
disability and mental health

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The NHS Confederation
The Papworth Trust
The Parkinson's Society
The Pasque Hospice
The Princes Royal Trust for Carers
The Stroke Association
Westminster Healthcare

Ambulance Service Association
Association of Directors of Social Services
British Dietetic Association
British Geriatric Society
British Association of Social Workers
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Society of Chiropodists and Podiatrist
Local Government Association
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Royal College of General Practice

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Cambridge County Council
Cheshire County Council
City of York Council
Cumbria County Council

Essex County Council
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Kent County Council
Leeds City Council
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Middlesborough Council
North Yorkshire Council
Redcar and Cleveland Council
Rotherham Metropolitan Council
Sheffield Council
Stockton on Tees Council
Sunderland City Council

Managers and clinicians from:
Addenbrookes Hospital NHS Trust
Airedale NHS Trust
Bradford Hospitals NHS Trust
Brighton & Sussex University Hospital NHS Trust
Central North West London Mental Health NHS Trust
City Hospital Sunderland NHS Trust
Ealing Hospital NHS Trust
East Kent Hospital NHS Trust
Harrogate Health Care NHS Trust
Hertfordshire Partnership Trust
Hitchingbrooke Hospital Health Care NHS Trust
Hull & East Yorkshire Hospital NHS Trust
Leeds Teaching Hospitals NHS Trust
Lothian University Hospital Trust
Merseycare NHS Trust
National Hospital for Neurology and Neurosurgery NHS Trust
Northumberland NHS Care Trust
Royal Liverpool and Broadgreen University Hospitals NHS Trust
St George's Healthcare NHS Trust
St Mary's NHS Trust
Southdowns Health NHS Trust
Sheffield Teaching Hospitals NHS Trust
South Tees Hospitals NHS Trust
South West London NHS Trust
Southern Derbyshire Acute Hospitals NHS Trust
Sunderland NHS Trust
Surrey Ambulance Service NHS Trust
United Lincolnshire Hospitals NHS Trust
Westcountry Ambulance Service NHS Trust
York Health Services NHS Trust
York Health Services Trust

Ashford Primary Care Trust
Camden Primary Care Trust
Central Liverpool Primary Care Trust

Epping Forest Primary Care Trust
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Woking Primary Care Trust

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The Modernisation Agency
National Patient Access Team

Useful abbreviations

A&E	Accident and Emergency
BCHS	Better care higher standards
CAT	Change agent team
CIC	Common information corps
CMHT	Community mental health team
CPA	Care programme approach
COPD	Chronic obstructive airways disease
CTPLD	Community team for people with a learning disability
DH	Department of Health
FNC	NHS funded nursing care
GP	General practitioner
HIA	Home Improvement Agency
IDT	Inter-disciplinary team
ICES	Integrating community equipment services
LAS	Local ambulance service
LD	Learning disability
LOS	Length of stay
LTC	Long-term care
MAU	Medical Assessment Unit
MDT	Multidisciplinary team
MH	Mental health
NHS	National Health Service
NLD	Nurse-led discharge
NSF	National Service Framework
ODPM	Office of the Deputy Prime Minister
PALS	Patient Advice and Liaison Service
PCTs	Primary care trusts
PEG	Percutaneous endoscopic gastrostomy
POD	Patients own drugs
RNCC	Registered nurse contribution to care
SALT	Speech and language therapy
SAP	Single assessment process
SITREPs	Situation report
StHA	Strategic health authority
SSD	Social services department
TTA	To take away
TTO	To take out

Glossary

Assessment:	a process whereby the needs of an individual are identified and their impact on daily living and quality of life evaluated.
Avoidable admission:	admission to an acute hospital, which would be unnecessary if alternative services were available.
Care management:	a process whereby an individual's needs are assessed and evaluated, eligibility for services is determined, care plans drafted and implemented, and needs are monitored and reassessed.
Care manager:	a practitioner who, as part of their role, undertakes care management.
Care package:	a combination of services designed to meet a person's assessed needs.
Care pathway:	an agreed and explicit route an individual takes through health and social services.
Care planning:	a process based on an assessment of an individual's needs that involves determining the level and type of support to meet those needs, and the objectives and potential outcomes that can be achieved.
Care programme approach:	the formal process (integrated with care management) assessing the needs for services for people with severe mental health problems.
Carer:	a person, usually a relative or friend, who provides care on a voluntary basis.
Commissioning:	the process of specifying, securing and monitoring services to meet identified needs.
Direct payments:	cash payments from social services in lieu of community services.
Gateway worker:	a person whose role is to strengthen access and to provide community triage for those who may need urgent contact with specialist mental health services, and to ensure smooth pathways between primary care and specialised services.
Independent sector:	includes both private and voluntary organisations
Multidisciplinary:	when professionals from different disciplines, such as social work, nursing and therapy, work together.
Multidisciplinary assessment:	an assessment of an individual's needs that has actively involved professionals from different disciplines in collecting and evaluating this information.

Protocols:	a plan detailing the steps that will be taken in the care and treatment of an individual.
Rehabilitation:	a programme of therapy and reablement designed to restore independence and reduce disability.

1. Introduction and overview

This publication has been compiled to assist health and social care commissioners, managers and practitioners working in the statutory and independent sectors to improve local hospital discharge policy and practice. It is based on research evidence, best practice and current thinking, and builds on the very successful *Hospital discharge workbook* first published by the Department of Health in 1994.

Additional information on avoiding unnecessary hospital admission and on discharge planning is available on the Change Agent Team website which is updated frequently as new information becomes available. A Learning and Improvement Network has also been set up to help organisations review and improve performance. See website: www.doh.gov.uk/jointunit/changeagents.htm.

The processes and practices for best outcomes and those that maximise independent living for all adults who are to be discharged from acute care, community hospitals and other settings are described. Although many of the principles outlined might apply equally to children, additional guidance on the needs of children as patients will be included within the forthcoming *National service framework for children*. Also, this workbook does not deal specifically with adults being discharged from mental health facilities. However, many individuals being discharged from hospitals will have other concurrent issues to be taken into consideration, such as mental health difficulties or learning difficulties. The publication is based on the understanding that:

- many people admitted to hospital fear the experience of hospitalisation and of losing their autonomy; they want to return to living their previous lives as soon as possible and every effort should be made to help them do so;
- acute hospitals should only be used for the delivery of the services that cannot be provided as effectively elsewhere in the health service, social care or housing system.

During 2003 the Change Agent Team will collaborate with the Modernisation Agency to publish additional ways of improving local practice.

1.1 Delayed transfer of care

The research literature on hospital discharge goes back at least thirty years and there is remarkable consistency in the research findings, which continue to report on the breakdowns in routine discharge arrangements. In particular, older people make up a disproportionate number of those whose discharge from hospital is delayed and who are waiting for other services.[1,2]

The Health Select Committee on Delayed Discharges argued that delays in discharge can be seen as the symptom, and cause, of poor bed management in hospitals and a failure of communication between health and social care. Beyond this analysis, the Committee argued the importance of focusing on the experience of individual patients.[3]

The problems concerning hospital discharge are of a number of different types, these include discharges that:

- occur too soon;
- are delayed;
- are poorly managed from the patient/carer perspective;
- are to unsafe environments.

The causes of these difficulties are diverse, and include:

- internal hospital factors (e.g. the timing of ward rounds; the wait for diagnostic test results; the delay in referring for a home assessment and of this taking place; the organisation and management of medication; and the availability of transport);
- co-ordination issues (e.g. the communication and organisation of different health, social care and other community-based services):
- capacity and resource issues (e.g. the limited availability of transitional and rehabilitation places; placement difficulties associated with care homes; and availability of a home care provider);
- patient/carer involvement/choice (e.g. the lack of engagement with patients and carers in decisions about their care and the limited availability of choice of care options; and the lack of involvement by independent sector providers in operational and strategic planning issues).

1.2 Improving discharge performance

Discharge from hospital is a process and not an isolated event. It should involve the development and implementation of a plan to facilitate the transfer of an individual from hospital to an appropriate setting. The individuals concerned and their carer(s) should be involved at all stages and kept fully informed by regular reviews and updates of the care plan.

Planning for hospital discharge is part of an ongoing process that should start prior to admission for planned admissions, and as soon as possible for all other admissions. This involves building on, or adding to, any assessments undertaken prior to admission. Local implementation of the single assessment process (SAP) needs to take account of this critical issue.

Effective and timely discharge requires the availability of alternative, and appropriate, care options to ensure that any rehabilitation, recuperation and continuing health and social care needs are identified and met.

1.3 The government's policy

A number of medium and longer term policy initiatives are in place that require close collaboration and joint planning across the health and social care system in order to deliver improved positive outcomes for patients. This applies particularly to the independent sector in ensuring that opportunities they offer are always considered and kept under review. These policies are supported by an investment plan linked to challenging performance targets, many of which have an impact on the processes that contribute to effective hospital discharge. These are described in more detail in Section 2.

1.4 Key principles

The key principles for effective discharge and transfer of care are that:

- unnecessary admissions are avoided and effective discharge is facilitated by a 'whole system approach' to assessment processes and the commissioning and delivery of services;
- the engagement and active participation of individuals and their carer(s) as equal partners is central to the delivery of care and in the planning of a successful discharge;
- discharge is a process and not an isolated event. It has to be planned for at the earliest opportunity across the primary, hospital and social care services, ensuring that individuals and their carer(s) understand and are able to contribute to care planning decisions as appropriate;
- the process of discharge planning should be co-ordinated by a named person who has responsibility for co-ordinating all stages of the 'patient journey'. This involves liaison with the pre-admission case co-ordinator in the community at the earliest opportunity and the transfer of those responsibilities on discharge;
- staff should work within a framework of integrated multidisciplinary and multi-agency team working to manage all aspects of the discharge process;
- effective use is made of transitional and intermediate care services, so that existing acute hospital capacity is used appropriately and individuals achieve their optimal outcome;
- the assessment for, and delivery of, continuing health and social care is organised so that individuals understand the continuum of health and social care services, their rights and receive advice and information to enable them to make informed decisions about their future care.

The benefits of effective discharge planning are:

for the patient

- needs are met;
- able to maximise independence;
- feel part of the care process, an active partner and not disempowered;

- do not experience unnecessary gaps or duplication of effort;
- understand and sign up to the care plan;
- experience care as a coherent pathway, not a series of unrelated activitities;
- believe they have been supported and have made the right decisions about their future care;

for the carer(s)

- feel valued as partners in the discharge process;
- consider their knowledge has been used appropriately;
- are aware of their right to have their needs identified and met;
- feel confident of continued support in their caring role and get support before it becomes a problem;
- have the right information and advice to help them in their caring role;
- are given a choice about undertaking a caring role;
- understand what has happened and who to contact;

for the staff

- feel their expertise is recognised and used appropriately;
- receive key information in a timely manner;
- understand their part in the system;
- can develop new skills and roles;
- have opportunities to work in different settings and in different ways;
- work within a system which enables them to do so effectively;

for organisations

- resources are used to best effect;
- service is valued by the local community;
- staff feel valued which, in turn, leads to improved recruitment and retention;
- meet targets and can therefore concentrate on service delivery;
- fewer complaints;
- positive relationships with other local providers of health and social care and housing services;
- avoidance of blame and disputes over responsibility for delays.

1.5 How to use the workbook

As previously described, effective discharge planning is a complex process. This workbook provides guidance on each of the specific stages involved within a whole system approach.

Each section provides an overview of the issues and sets out the key principles of good practice and the specific messages for:

- commissioners of health and social care;
- managers of health and social care;
- front line staff working with patients and carers.

1.6 References

1. Taraborelli *et al.* (1998). *Hospital discharge of frail older people: a literature review with practice case studies.* Edinburgh: Scottish Office Central Research Unit.

2. Audit Commission (2000). *Inpatient admissions and bed management in NHS acute hospitals.* London: The Stationery Office.

3. House of Commons Health Committee *Delayed Discharges (2001-02).* Vol. 1. London: The Stationery Office.

2. Background information: policy context

2.1 Introduction

The two White Papers *The NHS plan: a plan for investment, a plan for reform* and *Modernising social services* set out an agenda of intense reform, reinforcing the importance of health and social care working together in the planning and delivering of care.[1,2]

Other policies that relate to and have an impact on avoiding unnecessary hospital admission, the effective use and co-ordination of health, social care and housing resources and hospital discharge planning are:

- The Health Act.
- Building Capacity and Partnership in Care.
- Patient and Public Partnership in the new NHS.
- Carers (Recognition and Services) Act and the Carers and Disabled Children Act.
- NHS Funded Nursing Care in Nursing Homes.
- The Direction on Choice.
- Fair Access to Care Services.
- The National Service Framework for Older People (including medicines management).
- The National Service Framework for Mental Health.
- Valuing People.
- Supporting People.
- Community Care (Delayed Discharge, etc.) Bill (subject to Parliamentary approval).

The consistent and strong message within each of these is the need for statutory and independent agencies to work together with their local communities to plan, commission and deliver services. Strong and positive engagement is therefore essential. An equally clear expectation is that those individuals who require services, and their carers, will be actively and fully informed participants in the planning and delivery of their care. Effective clinical governance arrangements are to underpin the delivery of health care and, for local authorities, Best Value Reviews will ensure effective provision and use of social care services.

The Health Act 1999 paved the way for the NHS and local authorities with social service responsibilities to work together.[3] The introduction of joint priorities for health and social care adds further emphasis to the expectation that joint working will underpin the delivery of improved services and health gains in local communities. Practical guidance on using the flexibilities under the Health Act can be found on website: www.doh.gov/uk/jointunit.

The new powers resulting from the Act are:

- *Pooled budgets* – the ability for partners each to contribute agreed funds to a single pot, to be spent on agreed projects for designated services.
- *Lead commissioning* – the partners can agree to delegate commissioning of a service to one lead agency.
- *Integrated provision* – the partners can join together their staff, resources and management structures to integrate the provision of services from managerial to front line level.

Building capacity and partnership in care[4] launched a new agreement between the statutory and independent sectors to encourage a more strategic, inclusive and consistent approach to capacity planning at a local level. The independent sector is defined as providers of social care, health care and housing. Detailed information can be located on website: www.doh.gov.uk/buildingcapacity. The agreement promotes constructive co-operation between all parties involved in providing care and support for adults. It recognises the valuable contribution of the independent sector in managing capacity within a 'whole system approach'. It also provides advice on how capacity in the sector can be stabilised, increased and confidence in the market boosted. The principles contained in this document should be adopted.

Improvement, expansion and reform: the next three years[5] sets out the priorities and planning framework for health and social care. The areas in which the health and social care system will be changing are outlined. The emphasis is on more choice for patients, payment for results in the NHS and new incentives for health and social care to provide appropriate services for older people outside hospital. The need for improved access to services, improving the overall experience for patients and reducing health inequalities are highlighted.

2.2 Rights and responsibilities

Patient and public involvement in the new NHS[6] recognises that patients and their carers are the 'experts' in how they feel and what it is like to live with, or care for, someone with a particular condition. It is essential that any assessment and care planning process, continually engages the patient and their carers, and provides information in a way that helps them make unprejudiced decisions about treatment and care. Also, it is now a requirement that health trusts put in place Patient Advice and Liaison Services (PALS) to work with patients and their carers.

The booklet *Your guide to the NHS* replaced the *Patients' charter* and is available for the public, as well as patients in hospitals and community settings, to clarify NHS responsibilities and standards of care. Included in the booklet is a section on discharge from hospital and what help is available for ongoing care and support. The information is also available in audiocassette, Braille and a comprehensive range of languages and can be accessed on website: www.nhs.uk/nhsguide.

The Carers (Recognition and Services) Act 1995[7] and the Carers and Disabled Children Act 2000[8] acknowledge the important role that carers play and the need to help them maintain their own health and well being. The 2000 Act gives carers the right to have their own needs assessed and local authorities the power to supply certain services direct to carers. The role of carers must be taken into account in any discharge planning.

In October 2001, *Free nursing care in nursing homes*[9] enabled all people who were funding their own care (self-funders) to become eligible for the nursing component of that care to be funded by the NHS. In April 2003, the responsibility for assessing and funding nursing care for all care home residents transfers from local authorities to the NHS. The NHS responsibilities for funding care are based on meeting the costs of registered nurse time in providing, delegating or supervising care.

The guidance requires health and social care commissioners to work together to contract jointly with care home providers to meet individuals' care needs.

Although *patient choice* is considered extremely important, patients who have been assessed as not requiring NHS continuing in-patient care, do not have the right to occupy, indefinitely, an NHS bed (with the exception of a very small number of cases where a patient is being placed under Part 11 of the Mental Health Act 1983). They do, however, have the right to refuse to be discharged from NHS care into a care home. In such cases the hospital, social services and community staff should work with the patient and his or her family to find a suitable alternative. The *Direction on Choice* (LAC (92)27 and LAC (93) 18), that describes the current position is under review. Further information will be available on the Department of Health's website: www.doh.gov.uk.

Local authorities are responsible for carrying out community care assessments under Section 47(1) of the NHS and Community Care Act, and Section 47(3) should involve the NHS and housing, where appropriate.[10] They may provide community care services to individual adults who have needs arising from physical, sensory, learning or cognitive disabilities and impairments, or from mental health difficulties. If they are eligible, a care plan on how best to address those needs through the provision of either appropriate services such as home care, residential care, day care or direct payments. The local authority's responsibilities to provide such services are principally set out in the National Assistance Act 1948, the Health and Social Services and Public Health Act 1968, the Chronically Sick and Disabled Persons Act 1970, the National Health Services Act 1977, the Mental Health Act 1983 and the Disabled Persons (Services, Consultation and Representation) Act 1986.

The NHS and local authorities are bound by a duty to co-operate and to secure and advance the health and welfare of individuals (NHS Act 1977, NHS and Community Care Act 1990, Health Act 1999). The NHS is responsible for the assessment of continuing health care needs, in conjunction with social services. New guidance on continuing care was issued in June 2001,[11] which requires all strategic health authorities (StHAs) to review and agree new criteria for fully funded, continuing NHS health care. Primary care trusts and local authorities were required to be involved in agreeing these new criteria, and to have only one set of criteria across each StHA. In addition, the guidance stated that local authorities and the NHS should agree joint eligibility criteria for mixed packages requiring both health and social care.

Fair access to care services[12] requires local authorities, by April 2003, to review and make explicit, their eligibility criteria. The eligibility framework is graded into four bands – critical, substantial, moderate and low. The criteria should be graded by the risk that an individual, or his or her family, is exposed to. This will determine the nature of, and speed by which, services are provided. Local authorities should make only one eligibility decision with respect to adults seeking social care support. Separate criteria for specific types of services should not operate.

Reviews should take place at regular intervals. Local authorities are able to make direct payments to individuals as described in the Community Care, Carers and Children's Services (Direct Payments) (England) Regulations (2002) in accordance with the principles outlined in the Health and Social Care Act 2001 and the Children Act 1989. In 2003, every local authority is required to offer older people access to direct payments in the same way as they are available to younger people. This will mean that every older person assessed as being in need of care will be given the choice of receiving a service or a cash payment to purchase care for themselves that might better suit their needs.

2.3 Service standards

The *National service framework for older people* (NSFOP)[13] was published by the Department of Health in March 2001 and includes eight standards of care for older peoples' services. Each one contains key milestones.

1. *Rooting out age discrimination* aims to ensure that older people are never unfairly discriminated against in accessing NHS or social care services. Treatment services must be provided on the basis of clinical need alone.

2. *Person-centred care* aims to ensure that older people are treated as individuals and that they receive appropriate and timely packages of care which meet their needs as individuals, regardless of organisational boundaries. It includes specific plans that will have an impact on the organisation and co-ordination of care in preparation for discharge. These include implementation of:

   - *The single assessment process* (SAP)[14] is a standardised assessment process and care management system for older people. It aims to put individuals at the centre of their own assessment and subsequent care planning, lead to greater information sharing between professionals and encourage better outcomes for older people. Further information is available on the SAP website, www.doh.gov.uk/scg/sap;

   - *Community equipment services*[15] play a vital role in helping sick and disabled people of all ages develop their full potential and maintain their independence. They can also make it possible for informal carers, family members and professionals to manage someone at home, rather than in institutional care. Currently the NHS and local authorities have separate statutory responsibilities for equipment provision, which frequently causes confusion for users and practitioners and delay in providing vital equipment. Integration of these services will be taken forward through a three-year programme to deliver change involving housing, education, employment, the independent sector and specialist equipment providers. Integrated services and pooled budgets will deliver one local service and increase the range and capacity of equipment provision. The government has stated that by December 2004 all community equipment for older people (e.g. aids and minor adaptations) will be provided within seven days. Subject to legislation, from April 2003, the government plans to remove charges for community equipment, such as handrails and hoists. Further information is available on the ICES website: www.icesDH.org.

   - The delivery of *integrated continence services* by April 2003.

3. *Intermediate care*[16] aims to provide integrated services to promote faster recovery from illness, prevent unnecessary acute hospital admission, support timely discharge and maximise independent living. It sets out targets for increased provision of intermediate care services, which will enable acute hospitals to concentrate on what they are good at. See *Intermediate care: moving forward* (Department of Health, June 2002) for the latest information.

4. *General hospital care* aims to ensure that older people receive the specialist help they need in hospital and that they receive the maximum benefit from having been in hospital.

5. *Stroke* aims to reduce the incidence of stroke in the population and ensure that those who suffer a stroke have prompt access to integrated stroke services. This standard provides guidance on a care pathway for stroke care for all ages.

6. *Falls* aims to reduce the number of falls that result in serious injury and ensure effective treatment and rehabilitation for those who have fallen.

7. *Mental health in older people* aims to promote good mental health in older people and to treat and support those older people with dementia and depression.

8. *The promotion of health and active life in older age* aims to extend the life expectancy of older people.

Implementing medicines-related aspects of the NSFOP aims to ensure that older people gain maximum benefit from their medication to maintain or increase their quality and duration of life.

The *National service framework for mental health* (NSFMH)[17] sets out standards of care for adults of working age with mental health problems. People who receive specialist mental health services should be supported in accordance with the *care programme approach* (CPA) and have a care co-ordinator who is responsible for ensuring the delivery of a seamless health and social care plan. The NSFMH and Effective Care Co-ordination documents can be found on the website, www.doh.uk/nsf/mentalhealth.

Valuing people[18] emphasises the importance of providing people who have a learning disability with the services and opportunities that should be afforded to them in order that they can lead full lives. Of particular relevance to the provision of general health services is the need to provide equal access to health promotion and treatment services. Good practice guidance on *health action plans and health facilitation* to help people with learning disabilities use general health services can be found on website: www.doh.gov.uk/learningdisabilites.

Two other documents published by the Department of Health, *Signposts for success*[19] and *Once a day*[20], recommend that all acute hospitals take into consideration the special needs of people with learning disabilities, when they access hospital services.

The *Supporting people*[21] programme launched in January 2001, sets out important changes in the way housing and related benefits could be used to help vulnerable people achieve greater independence. These changes come into effect in 2003 through a working partnership arrangement between local government, service users and support agencies.

The lead organisation is the local authority. However, stakeholder organisations, such as health trusts and the independent sector, should contribute to the strategic plans for housing-related services, which will complement and change existing support services. This important initiative has a key role to play in the development and expansion of alternative care options.

Better care, higher standards (BCHS)[22] published in 1999 by the Office of the Deputy Prime Minister and the Department of Health promotes joint approaches on service standards and information provision across housing, health and social care in order to strengthen partnership working.

2.4 Future service developments

Delivery of *The NHS plan*[1] and *Modernising social services*[2] through the Priorities and Planning Framework will see a continued emphasis on service development. The key developments that will have an impact on the effective use of the acute hospital sector, promote independence and support older people or those with complex health and social care needs, to be delivered over the next five years, include:

- Each year
  - less than a 1% growth in emergency hospital admissions and no growth in re-admissions.
- During 2003
  - agree, implement and jointly monitor, local improvement plans as a result of surveys designed to explore the patients' experience, and involve Patient Forums as they become available;
  - strengthen accountability to local communities through improved engagement with them as evidenced by annual Patient Forum reports to the Commission for Patient and Public Involvement in Health, and annual publication of a patient prospectus covering local health services;
  - strategic and operational plans will include the development of an integrated continence service;
  - hospitals caring for people with stroke will have established clinical audit systems;
  - risk management procedures will be in place in all providers of health and social care to reduce the risk of older people falling;
  - strategic and operational plans will include a programme to promote healthy ageing and to prevent disease in older people; all general hospitals that care for older people will have completed a skills profile of their staff in relation to the care of older people and have in place education and training programmes to address gaps identified;
  - at least 500,00 extra pieces of community equipment will be provided free of charge to an estimated 250,000 people.

- April 2004
  - at least 5000 additional intermediate care beds and 1700 non-residential intermediate care places compared to the 1999/2000 baseline will be in place;
  - protocols will be in place across health and social care systems for the care and management of older people with mental health problems;
  - all general hospitals caring for people with stroke will have specialised stroke services;
  - single integrated equipment services will be in place.
- December 2004
  - for emergency care a single phone call to NHS Direct will be a one-stop gateway to out-of-hours healthcare;
  - all assessment of older people will begin within 48 hours of first contact with social services and will be completed within four weeks (70% in two weeks);
  - all community equipment for older people (e.g. aids and minor adaptations) will be provided by social services within seven working days.
- December 2005
  - for planned care, offer routine choice of hospital provider at the point of booking;
  - all health and social care systems will have an integrated falls service;
  - establish new diagnostic and treatment centres to support meeting 2005 waiting targets.
- March 2006
  - Improve the quality of life and independence of older people so that they can live at home wherever possible, by increasing the numbers of those supported intensively to live at home to 30% of the total being supported by social services at home or in residential care;
  - Carers Grant will be doubled.

During this period further *National service frameworks* will be developed that will have an impact on community- and hospital-based health services and on social care. One of particular significance to capacity within the health and social care system will be that on the management of chronic physical disabilities and neurological conditions.

2.5 References

1. Department of Health (2000). *The NHS plan: a plan for investment, a plan for reform.* London: Department of Health.

2. Department of Health (1998). *Modernising social services.* London: Department of Health.

3. The Health Act 1999. London: HMSO.

4. Department of Health (2001). *Building capacity and partnership in care.* London: Department of Health.

5. Department of Health (2002). *Improvement, expansion and reform: the next three years.* London: Department of Health.

6. Department of Health (2000). *Patient and public involvement in the new NHS.* London: Department of Health.

7. The Carers (Recognition and Services) Act 2000. London: HMSO.

8. The Carers and Disabled Children Act 2000. London: HMSO.

9. Department of Health (2001). *Free nursing care in nursing homes* (HSC 2001/17: LAC (2001)26). London: Department of Health.

10. The NHS and Community Care Act 1993. London: HMSO.

11. Department of Health (2001). *Continuing care: NHS and local councils' responsibilities* (HSC 2001/015: LAC (2001)18). London: Department of Health.

12. Department of Health (2002). *Fair access to care services* (LAC (2002)13). London: Department of Health.

13. Department of Health (2001). The national service framework for older people. London: Department of Health.

14. Department of Health (2002). *The single assessment process for older people* (HSC 2002/01: LAC 2001(1)). London: Department of Health. www.doh.gov.uk/scq/sap/hsc200201.htm

15. Department of Health (2001). *Guide to integrating community equipment services.* London Department of Health.

16. Department of Health (2001). *Intermediate care* (HSC 2001/1: LAC 2001(1)). London: Department of Health.

17. Department of Health (1999). *The national service framework for mental health.* London: Department of Health.

18. Department of Health (2001). *Valuing people.* London: Department of Health.

19. NHS Executive (1998). *Signpost for success.* London: Department of Health.

20. NHS Executive (1999). *Once a day.* London: Department of Health.

21. Department of Health (2000). *Supporting people.* London: Department of Health and Department of Environment, Transport and the Regions.

22. Department of Health (1999). *Better care, higher standards.* London: Department of Health and Environment, Transport and the Regions.

3. Developing a 'whole system approach'

The *key principles* underpinning this aspect of an effective discharge and transfer of care policy are:

- The avoidance of unnecessary hospital admission, good clinical outcomes and effective discharge planning is facilitated by a 'whole system approach' to the commissioning and delivery of services.
- Organisations should work proactively, separately and together to review and improve performance and find solutions.

The government has consistently emphasised the need for organisations and practitioners to work together to meet the needs of individuals and their carers. A 'whole system approach' is one that recognises the contribution that all partners make to the delivery of high quality care.

Whole system working does not have restrictive service boundaries – it puts the individual at the centre of service provision and responds to their needs. Patients, with their expertise and understanding of their own needs and their ability to influence how the discharge process works must be kept integral to the system. The whole system is not simply a collection of organisations that need to work together, but a mixture of different people, professions, services and buildings which have individuals as their unifying concern and deliver a range of services in a variety of settings to provide the right care in the right place at the right time.

The Audit Commission described how, 'Services for older people must work together if they are to meet people's needs and aspirations effectively. Many different agencies work with older people, including non-specialist services, such as transport, education and housing, as well as services that provide care. All too often older people receive a disjointed, confused response when they need help or advice. Frequently the responses that they receive meet their needs only in part'.[1] This builds on earlier work on rehabilitation services.[2]

3.1 What are the characteristics of whole system working?

- Services are responsive to the needs of the individual patient/client/tenant/carer.
- All stakeholders accept their inter-dependency and the fact that the action of any one of them may have an impact on the whole system.
- There is agreement between the stakeholders as to the vision of the service(s), the priorities, the roles and responsibilities, the resources, the risks and the review mechanisms.
- Those using the system do not experience gaps or duplication in provision.
- Relationships and partnerships are enhanced.

Guiding people through the system

A comprehensive range of services is not enough.

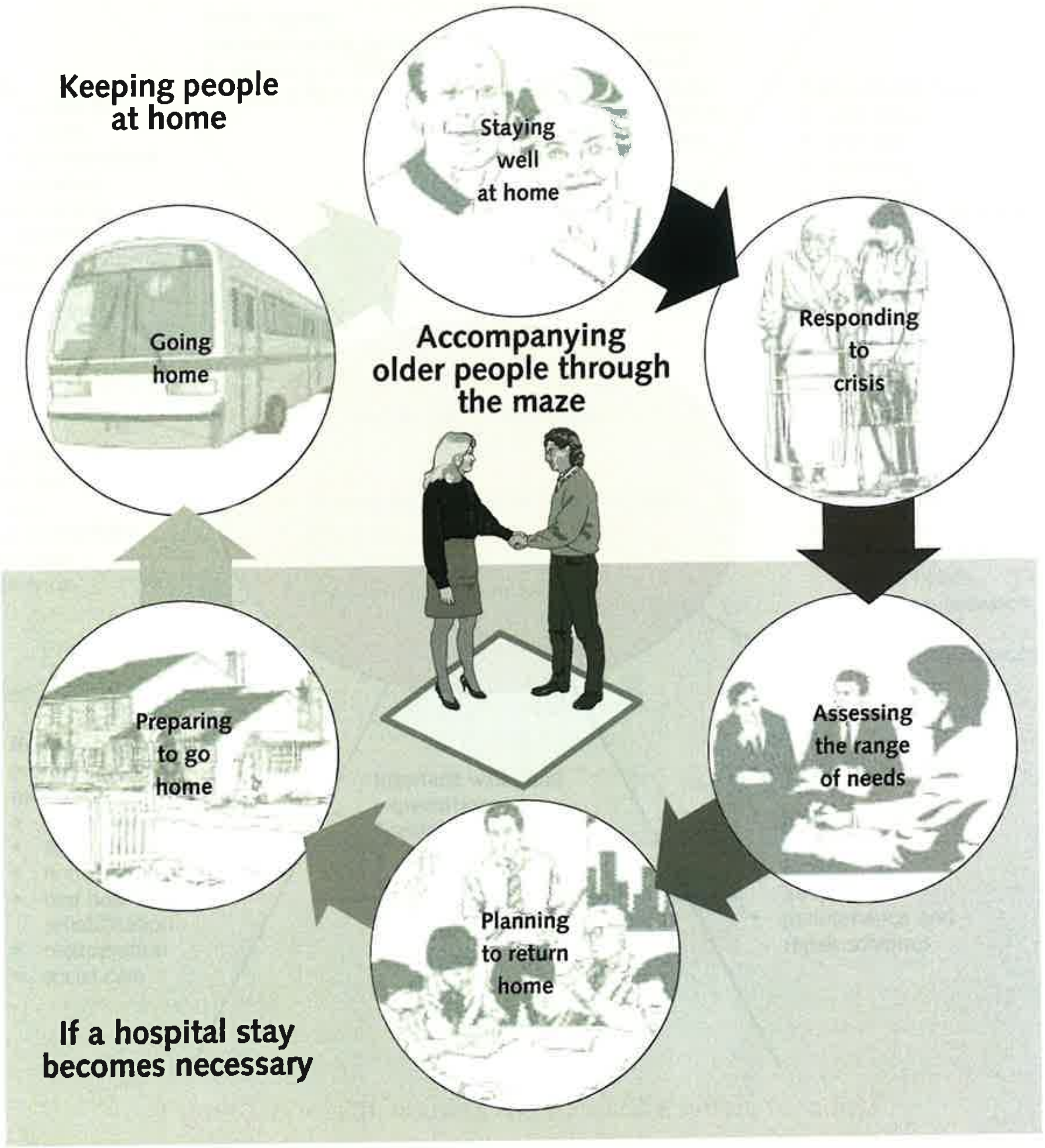
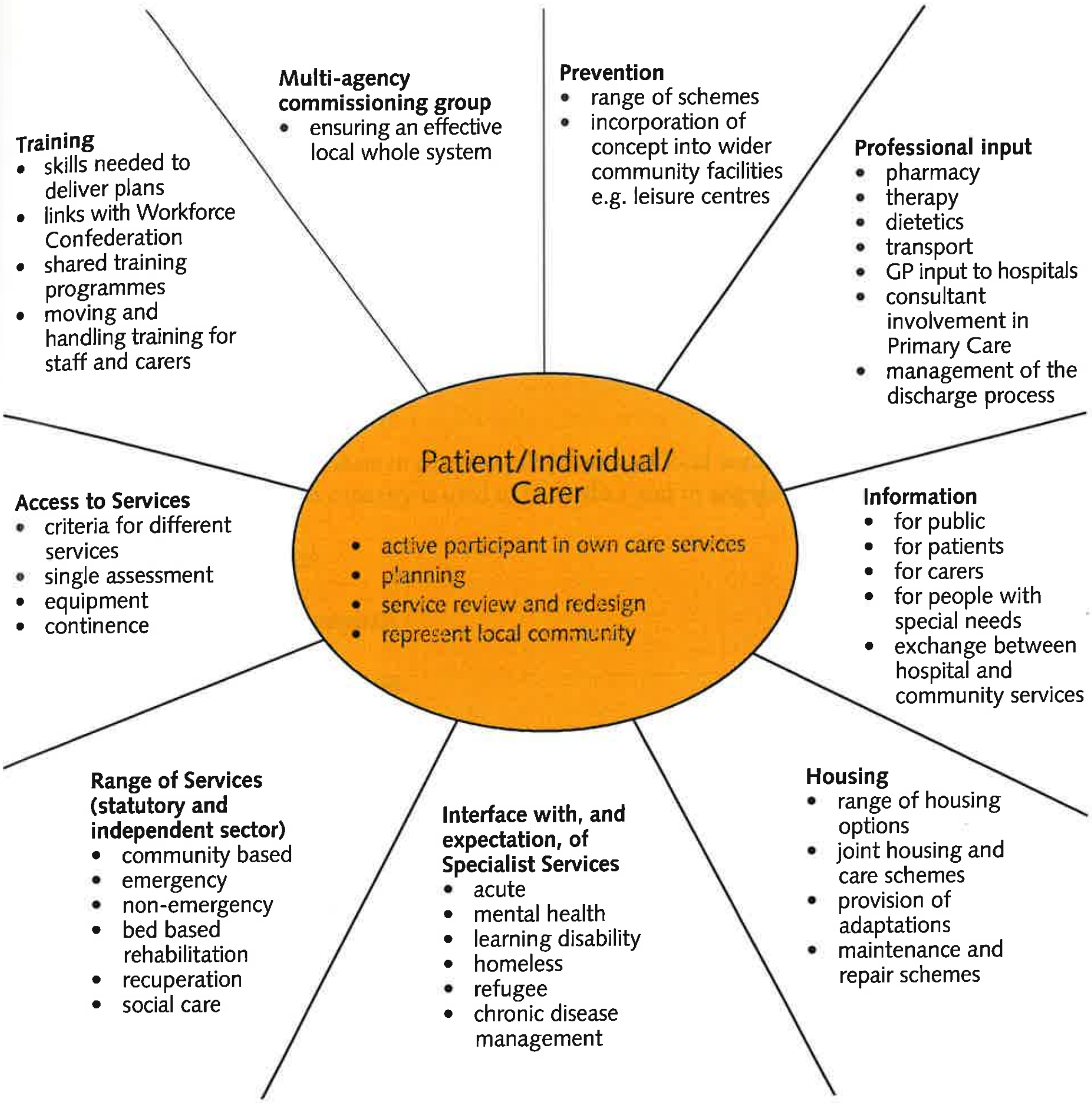


Figure 3.1. A 'virtuous' circle of services.

Source: Audit Commission (2002).[1]

3.2 Who is included?



Patient/Individual/ Carer
- active participant in own care services
- planning
- service review and redesign
- represent local community

Multi-agency commissioning group
- ensuring an effective local whole system

Prevention
- range of schemes
- incorporation of concept into wider community facilities e.g. leisure centres

Professional input
- pharmacy
- therapy
- dietetics
- transport
- GP input to hospitals
- consultant involvement in Primary Care
- management of the discharge process

Information
- for public
- for patients
- for carers
- for people with special needs
- exchange between hospital and community services

Housing
- range of housing options
- joint housing and care schemes
- provision of adaptations
- maintenance and repair schemes

Interface with, and expectation, of Specialist Services
- acute
- mental health
- learning disability
- homeless
- refugee
- chronic disease management

Range of Services (statutory and independent sector)
- community based
- emergency
- non-emergency
- bed based rehabilitation
- recuperation
- social care

Access to Services
- criteria for different services
- single assessment
- equipment
- continence

Training
- skills needed to deliver plans
- links with Workforce Confederation
- shared training programmes
- moving and handling training for staff and carers

Figure 3.2. Health, housing and social care system for adults.

3.3 Whole system working for effective hospital discharge

There are three main areas where integrated whole systems working underpins the discharge care pathway:

- Capacity planning.
- Reviewing performance.
- Hospital discharge policies and inter-agency agreements.

The infrastructure that is required to support this is described in Appendix 3.1.

3.3.1 Capacity planning

This requires commissioners in primary care trusts and local authorities to work together to ensure that the current capacity is used to best effect and to engage the independent sector in:

- Acute hospital.
- Community hospitals.
- Mental health services.
- Housing sector (further information is provided in Appendix 6.1).
- Transport services (Appendix 3.2 provides an overview of the transport).
- Care homes.

To increase capacity in services in order to avoid the need for admission to hospital and support earlier hospital discharge such as:

- Intermediate care.
- Intensive home support.
- Carers' support.
- Rapid response teams.
- Very sheltered housing (innovative use of local authority and Housing Association voids).

3.3.2 Reviewing performance

National targets are in place for a reduction in delayed transfers of care and emergency admission to hospital. These are noted in Section 2. The local performance of organisations is closely monitored through SITREPs. Many organisations have found that by working together to monitor and discuss the reason for delay they have been able to find joint solutions to some of the issues. In many areas the performance monitoring has been extended to identify and provide a more detailed analysis of the issues and improve the accuracy of the information.

The use of process maps to follow an individual's progress through the system has helped practitioners to understand and develop a fresh perspective on NHS and social services efficiency from the patient's view point. It is a powerful way of demonstrating to practitioners how their actions are viewed by the patient, the outcome of those actions and any duplication.[3] The Modernisation Agency has developed a guide to process mapping, analysis and redesign, which is available on their website: http://www.modern.nhs.uk/improvementguides/process. Service Improvement Managers in strategic health authorities may also be contacted for advice.

3.3.3 Hospital discharge policies and practices

The way that health and social care organisations work together in the hospital setting is critical to effective discharge/transfer planning. Primary care trusts, local authorities with social services responsibilities and acute hospital trusts, in partnership with independent sector providers, need to review and build on previous community care agreements.

The performance monitoring arrangements of delayed transfers of care should be detailed in the local discharge policy together with arrangements to validate information and agree actions to resolve, and investigate, concerns.

The policy, once agreed, will need to be understood by staff and its importance highlighted at staff orientation and induction programmes and through regular training.

The performance framework to monitor delays provides the means to review practice and revise the policy in a dynamic way as organisations learn what works well and what needs reform.

The policy should be readily available for patients, carers, their families and advocacy services and in a range of media formats to meet sensory and language needs.

3.4 The contents, characteristics and components of a good inter-agency discharge policy

The policy aims are to:

- ensure the patient is always treated as an individual and to provide continuity of care as they transfer from one care setting to another;
- ensure acute hospital facilities are used appropriately;
- identify and agree joint priorities for change.

The agreement should:

- describe the overall referral, assessment, care planning and review framework;
- set out clear guidance on professional and organisational responsibilities;
- streamline the referral processes between hospital departments, primary care and social care agencies, including the independent sector;
- contain locally agreed standards for interdepartmental response times;
- provide a performance and clinical governance framework;
- describe an education and training programme for staff;
- Describe an education and training programme for patients and carers;
- Determine the out-of-hours availability of the independent sector providers.

Key outcomes of the policy:

- Clinical protocols are agreed with the primary care trusts to ensure acute facilities are used appropriately.
- Risk assessment processes are integral to assessment and care planning.
- Actions to ensure safe and timely transfer are initiated prior to admission or as soon as possible after admission.
- Discharge/transfer planning is seen as a continuous process that takes place seven days a week.
- Patients and their carers are fully involved at all stages.
- Patients and their carers are provided with information, both verbal and written, and in a range of media formats (to take into account any sensory or spoken language needs) on what to expect and their contribution to the process.
- Staff work within the principles set out in the single assessment process for assessment and care management and ensure a named individual co-ordinates the patient's progress through the system.
- Staff engaged in discharge planning are fully aware of the treatment, rehabilitation and care options provided in the community in the statutory and independent sector and how to access them.
- Agreements are in place with the bordering local authorities and primary care trusts regarding eligibility for home care, care home placements and for those requiring NHS continuing care and home equipment.
- Clinical protocols are in place to facilitate nurse/therapist initiated discharge/transfer.

- Effective communication processes are agreed with community-based staff.
- A comprehensive range of checklists and records are provided to assist staff.
- Patients are provided with details of arrangements, contact details and any relevant information regarding their future treatment and care.
- Procedures are clearly defined for cases where the patients do not have the mental capacity to represent themselves.

There should be a section for each professional group such as doctors, nurses, therapists, pharmacists, social workers and care managers clarifying their *responsibilities* with regard to:

- Discussing with the patient the reasons for his or her admission, treatment, likely outcome and projected discharge date.
- Engagement and communication with the carer and/or family.
- Providing the patient and family with information.
- Co-ordinating the patient's journey.
- Communication with the patient's GP and primary healthcare team on admission, transfer and discharge.
- Referral for diagnostic, therapy, medication management and transport.
- Documenting the discharge/transfer plans.
- Planning and arranging reviews and follow-up appointments.
- Decision about fitness for discharge/transfer.
- Organising transfer/discharge.

Specific joint agreements/protocols for:

- Fast track arrangements for short-term enhanced home care packages.
- Patients who refuse to leave hospital.
- Placements in care homes.
- Out-of-hours access to the independent sector.
- Assessment of carers' needs.
- Avoiding premature discharge.
- Cross-border clients from a neighbouring local authority.
- NHS continuing care.

- Direction on choice.
- Unplanned discharge and discharge against medical advice.
- People who are homeless.
- Links with mental health and learning disability services.
- Use of interpreters, translators, Patient Advice and Liaison Services (PALS) and advocacy services.

3.5 Action steps

Senior managers from the primary care trust, acute trust and local authority with social services responsibility need to agree:

- who will lead a joint review of the discharge policy and information exchange practices between organisations;
- a timetable and terms of reference for the review;
- to provide feedback to the Local Capacity Planning Group on findings and pressures within the system related to capacity;
- an action plan to address findings;
- the immediate steps to improve the use of and access to information between agencies.

3.6 Practical example

A discharge planning self-assessment tool has been developed by health and social services staff to review policy and practice. This was developed from work carried out by South West Regional Office and the Social Services Inspectorate. This is provided in Appendix 3.4.

3.7 References

1. Audit Commission (2002). *Integrating services for older people.* London: The Stationery Office.

2. Audit Commission (2000). *The way to go home.* Oxford: Audit Commission.

3. NHS Modernisation Agency (2002). *Improvement leaders guide: process mapping, analysis and redesign.* www.modern.nhs.uk/improvementguides

Appendix 3.1
Supporting the system

A3.1.1 Why this matters

Experience has shown that working collaboratively produces the best environment for creating and sharing ideas that will improve services to patients and their carers. A collaborative approach has to include the planning of services, their delivery and the empowerment of practitioners to work in different ways and to test new models of delivering care. That is, everyone commits to identify and contribute to ways of improving the patient's journey through the care services. All parties are seen as equal and the independent sector plays a key role.

The key areas that underpin effective partnership working are:

- Leadership at all levels of the system.
- A shared vision and trust between the different partners.
- Communication across the system and within individual organisations.
- A shared approach to service monitoring and review.
- A culture that promotes reflective practice, service development and innovative practice.
- Clear agreements about sharing and managing financial risk.
- Multidisciplinary working and training.

Without addressing these areas there is an increased likelihood of:

- Patients, carers and staff being dissatisfied with the care they receive.
- Staff being dissatisfied with the services they offer.
- A blame culture within, and between, agencies.
- Limited service redesign and development.
- Increased capacity problems.
- An increase in bottlenecks in the system.
- Marginalisation and the stigmatisation of certain groups of patients.
- Gaps and/or duplication in services.
- A risk of people getting 'lost' in the system.

- Misunderstanding between patients and staff, carers and staff, and staff in different parts of the system.
- Delays in transfer of information between services as the patient moves, in getting community services set up to support discharge, in obtaining essential equipment and in getting housing adaptations in place.
- Staff not understanding local policy, practice and procedures leading to inconsistent information being given to patients, unnecessary delays and wasted effort on the part of staff.
- A reactive, not a proactive, approach to discharge.

A3.1.2 Leadership

Strong managerial and clinical leadership is required at all levels – across the whole range of services, at individual organisational level, at multidisciplinary team level and in individual departments.

At Chief Executive and Director level leadership is required to provide: a shared vision, a shared commitment to making the system work; agreement on priorities; development of shared policies and protocols; and budgetary management. The strategic vision should demonstrate a whole system approach to capacity and demand management. With strong senior leadership it is easier to manage the tensions that will occur from time to time. These will be internally, between organisations and with patients and carers who feel that they have not received the service they should have.

At senior/middle manager level, for example ward manager, modern matron, day service manager, departmental head, it is key that managers understand their part in:

- Developing policies and practices based on current thinking.
- Putting policy into practice and measuring the impact of change.
- Ensuring that staff understand the key role they play in the discharge process.
- Providing staff with tools and techniques to review performance and find solutions.
- Ensuring that staff see both patients and carers as equal partners in the care planning and delivery process.
- Facilitating multidisciplinary team working.
- Creating an environment, which encourages staff to make decisions, to feel a valuable part of the system and to deliver an effective service.

Also, there needs to be job shadowing and secondments between the statutory and independent sectors.

A3.1.3 Communication

Good communication is a pre-requisite for a well co-ordinated patient journey from pre-admission through to discharge. Staff involved in discharge/transfer planning are frequently working to conflicting pressures and priorities between organisations, professions and patients, carers and relatives.

It is essential that there is communication at all levels within a system if there is to be effective partnership working between organisations, within each organisation and between staff and the patients, carers and tenants they are working with. This also needs to extend to communication with the wider public about service plans, priorities, pressures, access routes and the roles and responsibilities of different organisations.

Common sources of tension between professionals and agencies are:

- Pre-judged referrals.
- Differing ideologies between health, social care and housing.
- Lack of engagement with patients and with carers.
- Duplication and overlap of assessment.
- The pace of assessment.
- Poor quality and inconsistent documentation.
- The need to progress chase between professionals and agencies.
- Poor/lack of information given to the independent sector about the patient when discharged.
- Lack of engagement with the independent sector.
- The inability to access information to plan discharge and by community staff following discharge.

Effective services benefit from an agreed communication strategy that is applied consistently throughout the whole system. This should be tailored to meet the needs of the various partners. It should state clearly the vision of the service, the roles and responsibilities of all partners and the means by which comments on the services will be responded to. Some communication strategies follow.

Who	What	How
Between organisations	• Resources available to provide services • Tensions between meeting national & local priorities • Interface arrangements with the Workforce Confederation • Management accountability & responsibilities at commissioning & service management level • Detailed information on delayed transfers of care by local authority wards, GP practice to look at reasons and possible action	• Agreed meeting structure based on lead responsibilities
With patients	• What they can expect from services – regarding their medical condition, prognosis & needs, pathway, length of stay, rehabilitation plans • Expectation of them • Choice protocol • How to complain	• Key worker discussion with patient • Leaflets • Videos
With carers	• What the can expect from services • Expectation of them • How to access a carer's assessment	• Key worker discussion with patient • Leaflets • Videos • Information in public buildings – libraries, health centres, schools
With staff	• Service plans • Priorities • Local vision for services • Service targets • Monitoring arrangements & reporting • Training & development opportunities	• Team briefing • Meetings with front line staff to learn of their ideas for service improvement and to help get behind performance data • Information with pay slips • Meetings with managers • Intranet
With the public	• Local service plans • How to access service • Costs, if any, of services	• PCT prospectus • Local authority directory of services • Annual reports

A3.1.4 Inter-agency training to improve the discharge process

Multidisciplinary team working has become one of the key processes through which health and social care is delivered. The organising principle is functional – i.e. individual departments recruit, manage and allocate their resources. The multidisciplinary team work together clinically, and consult one another regarding the management of patients, but generally will remain managerially aligned with the 'home' department. Professional boundaries can be very strong in many multidisciplinary teams, which may create conflict, often because there are overlaps in roles. This of course is time consuming and energy is wasted that could be more usefully applied to giving a seamless person-centered care for the patient.

The vision in the *NHS plan*, as described by the Modernisation Action team, for the professions and the wider NHS workforce is more in the spirit of interdisciplinary and even transdisciplinary working. Staff and resources in the interdisciplinary team are organised around a particular group of service users.[1] A single clinical head manages the service, and staff may still have professional links with their individual disciplines for continuing professional development and professional standards. Thus, collaboration occurs on a broader spectrum than in the multidisciplinary team as some blending of roles enables flexibility so that clinical demands can be met, especially if supported by cross-training between disciplines. Transdisciplinary teams take interdisciplinary working a step further in order to reduce duplication, particularly with regard to assessment and to make sure that individuals receive consistent information and treatment, with the needs of the user at the centre of the interventions.

As NHS-based multidisciplinary teams now also include social care staff, usually social workers, the challenges to those working in teams has increased. There is no best model for team working. The aim of the service should be to make informed decisions about which kind of team is best. However, the spirit of the single assessment process and person-centered care in the *National service framework for older people* would seem to favour inter- and transdisciplinary ways of working. This means that as well as having individual or uniprofessional training linked to continuing professional development plans, attention needs to be paid to team building and team working. This is essential for:

- The delivery of service plans.
- The clarity in the roles and responsibilities of team membership.
- Agreement on the leadership within the team.
- Understanding other organisations, other professions and other services.
- Making the best use of resources and enabling highly skilled personnel to focus on their areas of expertise and what they do best.
- Delivering a joined up service across parts of the NHS, and between local authorities and the independent sector.
- A consistent approach to individuals, e.g. rehabilitative approaches built into 24-hour care and not in isolation.

A3.1.5 Action steps

For primary care trusts and social care commissioners:

- Lead by example in supporting inter-agency working and to develop and sustain a culture that promotes innovation, reviews and develops practice according to need.
- Agree and make clear responsibilities regarding financial risk and local priorities.
- Agree a risk assessment framework to assist decisions about care options.
- Agree a joint training strategy that involves and supports the independent sector.
- Agree how delayed discharges are to be defined, monitored and reviewed, and for solutions to be sought in the context of overall performance monitoring.
- Support the development of information sharing protocols between NHS trusts and social services.
- Consider the skills offered by the independent sector in providing solutions to problems in a fast time scale.

For NHS and social care managers:

- Agree how to cluster interdisciplinary teams across the hospital in order to provide continuity of ward-based staff.
- Provide staff with the opportunity to have team training in order to understand each others roles and responsibilities, and to work with the local Workforce Confederation to provide appropriate multi-agency and multidisciplinary training.
- Hold regular team meetings to review and focus on complex discharge/transfer patients and possible care options.
- Agree a framework to review team performance and ensure this involves specific work to follow patients through the system. Provide feedback in order for professionals to review their own performance.
- Develop and work within protocols for non-medical discharge.
- Where teams are not working effectively, to provide external facilitation to explore the issues and agree improved ways of working.

A3.1.6 Practical examples

The Modernisation Agency has produced the 'Improvement Leaders Guides' programme to assist managers and staff improve performance. Further information is available on their website, www.modern.nhs.uk/improvementguides.

A3.1.7 Reference

1. Kumar, S. (2000). *Multidisciplinary approach to rehabilitation.* London: Butterworth-Heinemann.

Appendix 3.2
Transport

A3.2.1 Key issues

To use hospital resources effectively, it is essential that patients keep their appointments. Consideration, therefore, needs to be given to those patients who meet the criteria for transport, whether for an emergency admission, a planned discharge, a transfer to another care centre or an out-patient appointment. In the main, the local ambulance service and NHS hospital trust will provide *emergency transport*, but careful consideration should be given to the use of patients' own transport, friends and relatives, taxis and voluntary transport organisations.

Based on initiatives highlighted in the *NHS plan* and following advice from the Audit Commission and the Social Exclusion Unit a review of current practices for *patient transport services, social and community transport* and the future integration of transport services is recommended. There are also initiatives surrounding electronic booking for both clinical and transport needs, aligned with the overall approach to patient choice.

Primary care trusts are responsible for the commissioning of transport across their geographical area. With their local acute trusts and local ambulance service NHS trusts, they need to consider:

- Emergency provision within their geographical area and extended services to meet the patient choice option for travel to other care centres.
- Non-emergency provision within their geographical area and extended services to meet the patient choice option for travel to other care centres.
- Joint working with acute, community and ambulances services to develop strategies to maximise the effective use of transport resources in order to:
  - reduce wasted journeys;
  - reduce journey times;
  - reduce delayed discharges;
  - co-ordinate inward and outward journeys;
  - synchronise discharges/transfers with other outward journeys;
  - make effective use of admission/discharge suites;
  - provide timely support for home assessment visits;
  - effective co-ordination of out-patient appointments with geographical planning;

- provide designated appointment times for out-patients requiring transport;
- reduce unnecessary waiting times of ambulance crews, which limit their ability to respond to other areas of need;
- make transport an integral part of the patient's pathway of care;
- ensure receiving units are ready to accept patients.

A3.2.2 Action steps

For primary care trusts to:

- lead a review of current transport arrangements with the local ambulance service and NHS hospital trusts to establish whether current contracts meet the present and future needs;
- work with provider services to develop a local policy to accommodate out-of-area referrals to meet access targets and meet the implications of patients requiring transport to travel to distant treatment centres through patient choice;
- review the criteria for on-going eligibility for use of an ambulance for out-patient appointments.

For senior managers in acute trusts to:

- work with the primary care trust and local ambulance service colleagues to establish admission/discharge lounges;
- review with the local ambulance service the use of discharge lounges, where they exist, and their effectiveness;
- review out-patient booking schedules for patients requiring transport, to allow local ambulance services to support day hospital and day surgery units at the start and the end of the day, prior to transporting out-patients;
- work with local ambulance service colleagues to review integrated electronic patient information and transport booking systems;
- review the use of admission/discharge suites to effect earlier bed availability and the reduction of local ambulance service waiting times for admissions and discharges.

For out-patient managers to:

- consider geographical planning of out-patients' appointments;
- co-ordinate outward journeys with discharges/transfers.

For primary care trusts, local ambulance services and social services to:

- consider the opportunities for sharing resources and for central co-ordination.

- provide designated appointment times for out-patients requiring transport;
- reduce unnecessary waiting times of ambulance crews, which limit their ability to respond to other areas of need;
- make transport an integral part of the patient's pathway of care;
- ensure receiving units are ready to accept patients.

A3.2.2 Action steps

For primary care trusts to:

- lead a review of current transport arrangements with the local ambulance service and NHS hospital trusts to establish whether current contracts meet the present and future needs;
- work with provider services to develop a local policy to accommodate out-of-area referrals to meet access targets and meet the implications of patients requiring transport to travel to distant treatment centres through patient choice;
- review the criteria for on-going eligibility for use of an ambulance for out-patient appointments.

For senior managers in acute trusts to:

- work with the primary care trust and local ambulance service colleagues to establish admission/discharge lounges;
- review with the local ambulance service the use of discharge lounges, where they exist, and their effectiveness;
- review out-patient booking schedules for patients requiring transport, to allow local ambulance services to support day hospital and day surgery units at the start and the end of the day, prior to transporting out-patients;
- work with local ambulance service colleagues to review integrated electronic patient information and transport booking systems;
- review the use of admission/discharge suites to effect earlier bed availability and the reduction of local ambulance service waiting times for admissions and discharges.

For out-patient managers to:

- consider geographical planning of out-patients' appointments;
- co-ordinate outward journeys with discharges/transfers.

For primary care trusts, local ambulance services and social services to:

- consider the opportunities for sharing resources and for central co-ordination.

For local ambulance service managers to:

- review the viability and implications of local ambulance service staff giving information to hospital staff regarding the patient's environment, which may have an impact on discharge planning.

A3.2.3 Good practice examples

- The establishment of an admissions/discharge suite with easy vehicle access.
- Agreement between clinical staff and the local ambulance service of a simple checklist that is completed prior to booking transport.
- Agreement with GPs and clinicians that patient transport requirements will be reassessed regularly as recovery progresses and mobility increases.
- Nursing staff spending time with the local ambulance service as part of their induction to understand its operational procedures.
- A transport office within each acute hospital manned by the local ambulance service to co-ordinate patients' transport requirements.

Appendix 3.3
Discharge planning self-assessment tool

Topic	Questions	Self Assessment
Leadership and planning	Is a senior level planning group in place and are all the key stakeholders involved.	
	Is the group proactive about improving discharge management.	
	Does membership include individuals plus carers and all stakeholders (primary and secondary care, social services and housing, ambulance services, key clinicians, independent and voluntary sectors).	
	Is leadership sufficiently senior with clear accountability.	
	Is there acknowledgement that discharge planning is a joint responsibility.	
	Does the group monitor and evaluate the discharge planning process.	
	Are there agreed ceilings for the maximum number of delayed transfers.	
	Are Health Act flexibilities being considered to develop integration and reduce boundary issues.	
Discharge policy	Is there a discharge policy.	
	Has it been agreed by all stakeholders.	
	Is implementation of discharge policy and protocols being audited.	
	Is there an agreed joint protocol to identify the carer's needs.	
	Does it include time frames for each stage of the process.	
	Does the policy (or accompanying procedure) include practical guidance.	
	Have eligibility criteria for transfers and continuing care needs been jointly agreed in order to avoid delays or duplication.	
	Are protocols in place to manage disputes about discharge e.g. self-discharges, patient choice, patients refusing discharge.	
	Is there an agreed interpretation of *patient choice* in terms of long-term care (LTC) placement. Has this been documented and provided to staff and patients.	
	Are protocols in place to manage different patient groups, e.g. mental health, children, various discharge destinations, rapid discharge.	

Topic	Questions	Self Assessment
Communication and Co-ordination	Is there a ward-based care co-ordinator (or equivalent) in post. If so, is the role clear to stakeholders and operational staff.	
	Is there an integrated discharge planning team approach.	
	How are the different functions co-ordinated, i.e. assessment, bed management, education and discharge facilitation.	
	How are links to intermediate care services co-ordinated.	
	Is discharge planning support available seven days a week and for extended hours.	
	Are clear communication mechanisms in place between agencies, disciplines and settings Do they work.	
	Has a discharge checklist been produced and publicised (see Appendix 5.2).	
	Is information available for patients and carers about discharge and transfer arrangements and expectations.	
	Is adequate IT available to support communication and monitoring.	
	How is the accuracy and consistency of verbal communication, particularly with patients and carers, monitored and recorded.	
	Are community services contacted within 24 hours of admission, to inform and to establish pre-admission status.	
	Does a ward-based care co-ordinator have responsibility for co-ordinating and monitoring discharge.	
	Is there a jointly agreed system for sharing information with health and social care services.	
Assessment	Is discharge planning started on admission (or pre-admission where applicable).	
	Is a provisional discharge date set within 24-hours of admission and reviewed regularly (daily).	
	Is an accredited single assessment process (SAP) in place/planned to be in place.	
	Does the SAP make provision for risk assessment	
	Does the assessment consider mental health requirements.	
	Does the assessment include triggers for referral onto other disciplines or agencies.	
	Is timely access to support services available, e.g. diagnostics, consultant opinion or pharmacy.	
	Are there agreed target times for completion of assessments.	
	When a patient is transferred does the provisional discharge date remain intact.	
	Are opportunities for rehabilitation fully explored before a LTC placement is made.	

Topic	Questions	Self Assessment
Documentation	Is basic patient information recorded only once.	
	Are unified records established.	
	Do patients have a copy of their care plan at the point of discharge.	
	Are discharge letters sent to GPs within 24 hours	
	Are integrated care pathways in place for key conditions.	
	Is the data collected on delayed transfers of care accurate, based on national definitions and is it used to evaluate the process and target resources.	
	Is effective use made of SITREP and CIC data including delayed transfers of care and reasons for delays.	
Data collection	Is there agreement as to why a discharge is delayed.	
	Are trends and variations of demand identified and linked to service planning.	
	Is the discharge process audited against expectations and outcomes.	
	Are LOS and readmission rates being monitored.	
Discharge	Are special arrangements in place to support rapid transfer or discharge.	
	Is there a mechanism to ensure the following are managed and do not lead to a delay: equipment, patient information, medication, discharge letter, set up or reactivation of community services, home preparation, settling in if required, transport, carers notified, follow up arrangements (including named contact in event of difficulties).	
	Is support and information available for staff, e.g. through discharge co-ordinator, discharge handbook and/or discharge pathway.	
	Is a discharge lounge (or equivalent) available and is it used effectively by all directorates.	
	Do ward rounds take place at a time and frequency to support discharge.	
	Are medication/drug dispensing arrangements in place to prevent delays in discharge.	
Training and Education	Are education and training opportunities available to all staff concerned with discharge planning.	
	Are arrangements in place to repeat training sessions at six-monthly intervals	

Source: Adapted from work done by the South West Regional Office and Social Services Inspectorate.

4. Involving patients and carers

The *key principle* underpinning this aspect of effective discharge and transfer of care is:

- The engagement and active participation of individuals and their carer(s) as equal partners is central to the delivery of care and in the planning of a successful discharge.

4.1 An overview of the issues

The concept of *person-centred care* is at the heart of NHS and social care reform.[1] As the *National service framework for older people* described, the aim is to, 'ensure that older people are treated as individuals and they receive appropriate and timely packages of care which meet their needs as individuals, regardless of health and social care boundaries'.[2]

Establishing a clear and common understanding of person-centred care is not without difficulty. As some recent research has indicated, for many health professionals patient-centred care focused predominantly on professional practice and keeping patients informed.[3]

A patient-centred approach must also recognise the important contribution made by carers. Government policy has raised the profile of carers and given them their own rights to assessment and services. It is important to remember that young people also may be carers and that they should be offered a carer's assessment if they are under 16 years of age, when the adult receives a community care assessment. These rights are described in Section 2.

Carers' organisations, however, continue to report concerns that carers issues are often marginalised, and patients continue to be sent home too early, with carers left to cope in the community with unacceptable caring situations.[4] A recent survey by Carers UK found that 43% of carers considered they were not given adequate support when the person returned home.[5]

Investigations into patient's and carer's experiences have consistently identified factors that have caused delayed access to services and prevented their subsequent progress through the system.[6] They report feelings of, 'having to fit in' and of 'feeling anxious, insignificant and powerless'. Conversely, good relationships enabled patients and carers to put their points across and feel involved. They report wanting consistent information, presented in an honest and sympathetic way. This helped patients and carers gain confidence in the system and a 'feeling we had some degree of control over what was happening'.

The development of patient-centred care requires the transformation of the professional/patient and carer relationship so that they are fully involved as partners in all stages of discharge planning. Patient-centred care must be much more than just keeping the patient informed and up-to-date with decisions about their care as passive players in the process.

The power and control exhibited by many professions needs to change from one of professional dominance to one where power and control is shared. Professionals bring the professional and technical expertise, patients and carers bring their individual experience, expertise and aspirations (Figure 4.1).

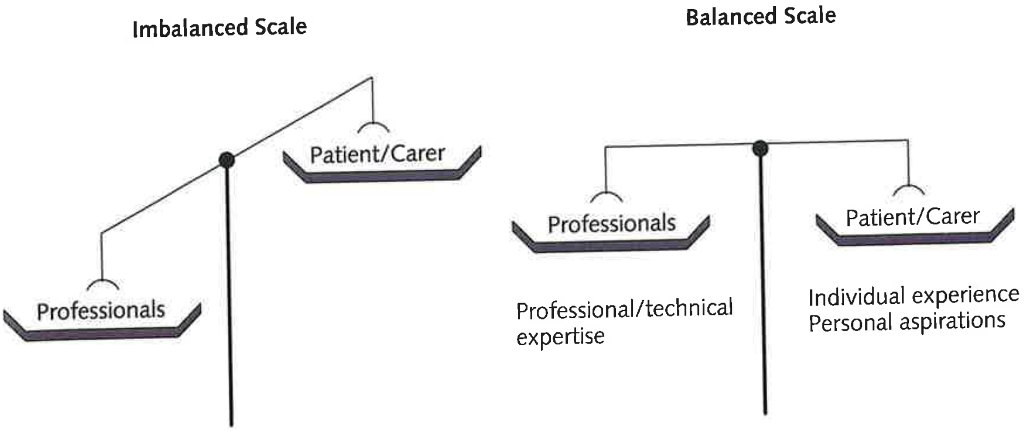


Figure 4.1. Power and control.

4.2 Key features to achieve successful involvement

Good communication skills are a fundamental component of a patient-centred approach. An active training and development strategy is required to equip staff to deal with the sharing of power.[7] Many innovative schemes involve patients and carers in education and training programmes and use their experiences of care to powerful effect.

The provision of information/discharge folders to the patient can be helpful. The patient and carer can have their own record of events and future plans, thus enabling them time to look through the information at their own pace, ask questions and raise their concerns. Care must be taken to ensure that a patient who has communication difficulties, e.g. after a stroke, is involved as fully as possible in planning his or her care.

Pre-admission assessment also helps the patient and carer plan for admission to hospital and to understand what to expect and prepare for on return home. There are many good examples where effective pre-admission processes are in place for elective admission.

For those people who are in receipt of packages of support prior to admission there is an opportunity to anticipate and pre-plan for likely problem areas. It is particularly important that the community care co-ordinator (or key worker, for people with a learning disability or mental health problem) should be fully involved in this process to support hospital practitioners meet the specific needs of these individuals and to support carers. For patients with learning disability this will form part of their health action plan (more detail on this is provided in Appendix 5.6) . This approach should become routine practice for elective work.

For patients admitted as an emergency, pre-admission planning obviously cannot take place. Many people admitted to hospital in this way can become frightened and disorientated. Staff need to be aware of this in their work with all patients and their carers. It can, however, be particularly important to recognise this if, in addition to physical ill health or trauma, someone admitted has a learning disability, mental ill health and/or appear to be confused. The change of environment and the nature of acute hospitals can quickly lead to a loss of independence or possibly the development of behaviour that causes distress to other patients. Staff can often find such behaviour a challenge to deal with.

Under stressful circumstances, such as an emergency admission, it is even more important to recognise the role of the carer from the start of the process in order to ensure that all the stages are well managed.

The admission process is the critical time to explain to patients and their carers what to expect and how they are to be involved in key decisions, remembering that they are the experts in how they feel and what it is like to live with, or care for, someone with a particular condition or disability. Any form of communication must take account of the individual's ability to understand and absorb information. The same information will need to be available in plain language and in a variety of appropriate forms. This should include, for example, appropriate minority and ethnic languages and presentations in large print, Braille and British Sign Language. Other formats might also be appropriate including audiotapes and visual formats such as interactive CD-rom. For some patients it will be necessary to involve an advocate or interpreter to provide further assistance. Every effort must be made to ensure consistency and continuity of information from different personnel.[8]

From the point of admission a ward-based care co-ordinator should be designated to co-ordinate care and ensure discharge planning proceeds smoothly. The role of care co-ordination is described in Section 5.

The Modernisation Agency have developed an 'Improvement Leaders Guide on Working with Patients and Carers' website: www.modern.nhs.uk/improvementguides/patients/shim.gif

4.3 Assessing need

It is important from the outset that patients feel understood and able to discuss what they perceive as their real concerns and worries. Asking patients how they like to be addressed (and ensuring this is passed on) shows sensitivity and respect. Also when undertaking an assessment, asking what is meaningful to them. This is especially important for older people as staff can often overlook the fact that an older person has a rich life history and is probably terrified that their sense of who they are is about to be denied. When these important points are omitted patients may be labeled as difficult and uncooperative when they perceive themselves to be in conflict with those staff responsible for their care. The introduction of the *single assessment process* for older people will ensure the appropriate areas of assessment are covered. Well developed interpersonal skills are essential if a trusting and collaborative professional patient relationship is to be established.

Staff should understand that patients and their carers may have different needs from each other, and that carers are entitled to a separate assessment. In circumstances where patients have the mental capacity to contribute to the planning of their care, permission to share information with the carer should be actively sought. There will be times when the mental capacity of the patient does not allow this and the next of kin is responsible for taking on this role. A carer's assessment checklist is provided in Appendix 4.1.

All individuals who provide regular and substantial care for a person with mental health needs who is on a care programme approach should:

- have an assessment of their caring, physical and mental needs repeated on at least an annual basis;
- have their own written care plan, which is given to them and which is implemented in discussion with them.

In circumstances where patients refuse permission to allow the carer to be involved in decisions about their future care, carers should be informed of this and their right to an assessment reinforced. There may be occasions where a carer's needs or wishes conflict with the patient's aspirations and in these situations staff teams should review the care plan and endeavour to find a realistic solution for all concerned. A multidisciplinary case conference is one way of joint working to find a suitable way forward.

With adequate support, carers will often be willing to take on or continue with a caring role. However, they should be given time to consider their options in making what are often life-changing decisions. These may be about how much and what type of care and the impact on their life and commitments and the financial consequences of the caring role. Attention should be directed to ensuring that carers are informed about the support networks and services that may be available to them. The needs of the carer should be under constant review to take account of their personal health and social care needs as well as the caring role they are undertaking. The assessment and review process should consider the need for a short-term break from caring. Additional resources have been provided under the Carer's Grant for this purpose.

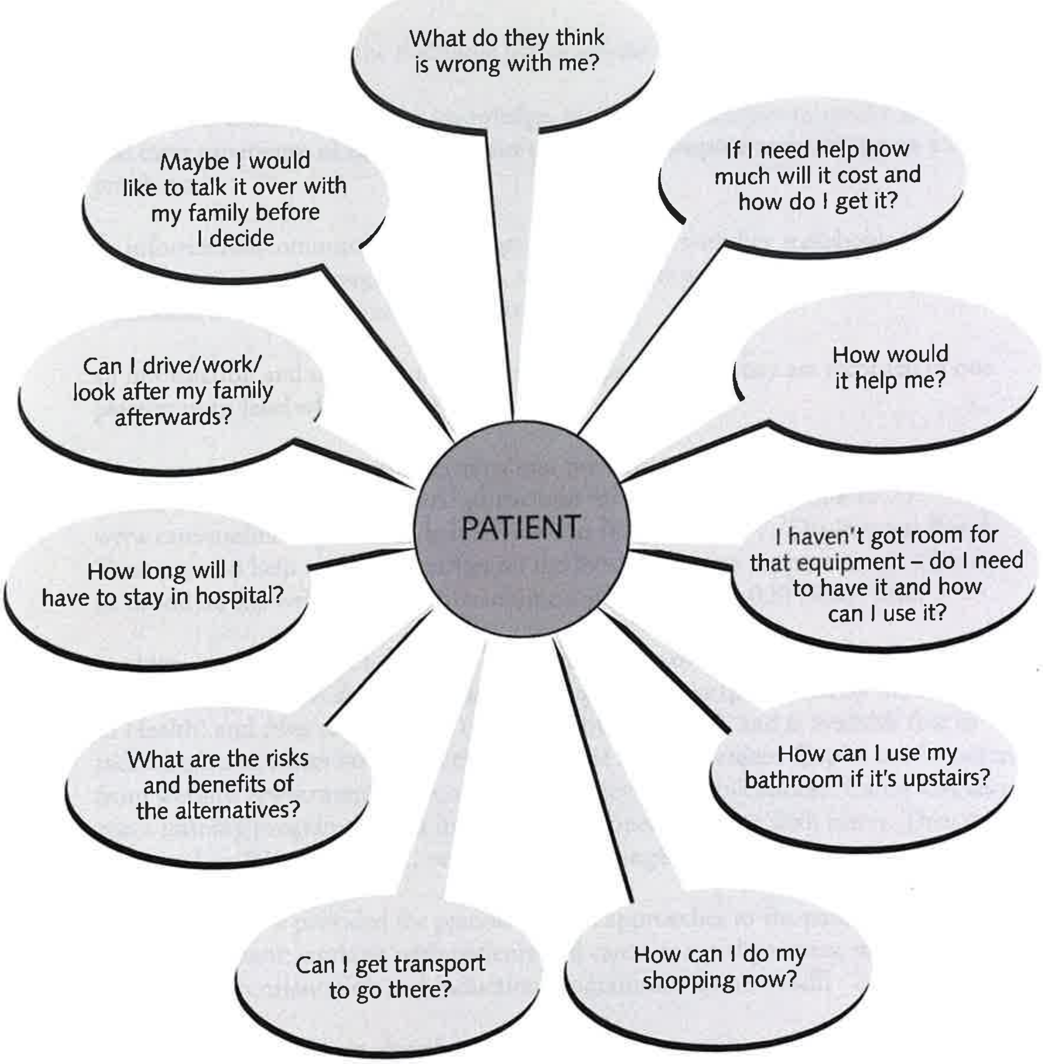


Figure 4.2. Some common questions.

Strategic health authorities and primary care trusts must make sure that appropriate information is available to patients, their families and any carers, about procedures for hospital discharge and about assessments for continuing health and social care, continuing NHS health care or social care support to help them make these decisions.[9] This is covered in Section 7.

In planning for discharge, attention should first be given to whether or not an individual's primary need is for health care and if they therefore satisfy the local eligibility criteria for fully funded continuing NHS health care.

Patient and carer discharge standards and rights are set out in Appendix 4.3. These were adaptedfrom the work of the discharge liaison nurses at York Health Services Trust.

4.4 Action steps

Those responsible for reviewing the discharge policy should take account of the following:

- staff have available to them the knowledge, tools and techniques to review the patient and carer experience of care throughout their stay in hospital and take action to resolve problems;
- an information/communication strategy is established with key stakeholders to assist patients and carers through admission, transfer of care and discharge *involve* patients and carers in the development of the strategy;
- all information and decisions that relate to the patient's journey are recorded in one place at ward level whilst an in-patient;
- carers are provided with information about their own rights and how to get help. Carers UK can provide help and information for carers. Their website is: www.carersonline.org.uk and their advice line: 0808 808 7777. The Princess Royal Trust can also help with information on the local services to support carers. This can be found on the website: www.carersonline.org.uk or phone 020 7480 7788;
- booklets are provided to help carers understand their own rights. Two useful publications are *How do I get help in looking after someone* (published by the Department of Health) and *How do I get Help* (published by Carers UK and is available free to individuals and carers however a charge is made for bulk orders. Copies can be ordered from website: www.carersonline.org. under policy and publications). Carers UK also run a training programme that includes practitioners working with carers. They can be contacted on 020 7566 7632, or by e-mail: training@ukcarers.org;
- annual training is provided for practitioners in approaches to the patient's and to the carer's assessment; working with patients and carers as equal partners, will also need to be included in orientation and induction programmes for new staff;
- carers' training needs are identified and ensure discharge planning makes provision to meet those needs;
- short-term car parking facilities are provided as close to the ward as possible to enable carers and their families to collect patients;
- information on voluntary transport schemes is provided.

4.5 Practical examples

4.5.1 Carer's checklist

The list below is part of a helpful discharge good practice guide published by Carers UK. The full set of information is available through their website: www.carersonline.org.uk or by e-mail: info@ukcarers.org.

- Actively seek permission from the patient to share information with the carer.

- Provide carers with information about:
  - discharge plan in writing and verbally;
  - medical condition of the patient;
  - carer's right to an assessment;
  - what is likely to be involved in caring;
  - benefits;
  - financial implications of caring;
  - charging for services;
  - other sources of help and support organisations such as self-help groups;
  - access to signers/interpreters to enable effective understanding and communication;
  - challenging decisions and complaints procedures;
  - sufficient notice about discharge;
  - organising transport arrangements;
  - information about support to stay in or return to employment and/or education.
- Discharge information:
  - provide the patient and carer with a folder/booklet to record relevant information that they can take home with them.
- Patient and carer information:
  - purchase and loan out books from the series *Books beyond word.* The series is for people who can't read and is very useful for people who do not speak English. The series is published by the Royal College of Psychiatrists, Booksales, 17 Belgrave Square, London SW1X 8PG. Tel 0207 235 2351.
- Relatives/carers meetings:
  - hold evening/weekend clinics where relatives and carers can book an appointment with the social worker, consultant, ward-based care co-ordinator.
- Even up the odds:
  - provides patients and carers with access to independent/informal support at important meetings with professionals to help them put their point across and fully understand the situation/information they are being given.

- Training:
  - use pharmacy technicians to provide medication advice and training to patients and carers. This has been shown to improve medication compliance (see Appendix 5.1).
- Equipment:
  - demonstrate the correct use of any equipment prior to discharge and ensure follow-up arrangements are in place to check equipment provided is adequate, being used correctly and that patients and carers are given further training if required.

4.6 References

1. Department of Health (2000). *Patient and public involvement in the new NHS.* London: The Stationery Office.

2. Department of Health (2001). *The national service framework for older people.* London: Department of Health.

3. Gillespie, R. (2001). *Engaging with patients.* London: King's Fund.

4. Carers England (2002). *Hospital discharge practice briefing.* London: Carers UK.

5. Mather, J. *et al.* (2000). *Carers 2000.* London: Office of National Statistics.

6. Preston, C., Cheater, F., Baker, R. and Hearnshaw, H. (1999). Left in limbo: patients' views on care aross the primary/secondary interface. *Quality in Health Care* **8**: 16–21.

7. Audit Commission (2002). *Integrated services for older people.* London: The Stationery Office.

8. Department of Health (2000). *Patient and public involvement in the new NHS.* London: Department of Health.

9. Department of Health (2001). *Continuing care: NHS and local councils responsibilities* (HSC2001/015:LAC(2001)18). London: Department of Health.

Appendix 4.1
Carer's assessment checklist

This follows the modules in the *Practitioners guide to carers assessment* issued with guidance on the Carers and Disabled Children's Act 2000.

Not all modules will be appropriate to all carers. However, it is suggested issues marked * are always addressed with the carer (based on work carried out by Hertfordshire County Council and Hertfordshire Partnership NHS Trust):

*1. Carers' role.

*2. Breaks and social life.

*3. Physical and mental well being.

4. Relationships and mental well being.

5. Care of the home/s.

6. Accommodation.

*7. Finances.

*8. Work (where carer is of working age).

9. Education and training.

10. Current practical and emotional support.

11. Wider responsibilities.

12. Future caring role.

*13. Emergencies/alternative arrangements.

14. Access to information and advocacy.

*15. Personal safety and risk management.

*16. Agreed outcomes.

17. Complaints and challenges.

*18. Review.

19. Any issues around charging.

Appendix 4.2
Carer's assessment and care plan

To be completed by the assessor AND the carer possibly with a helper/advocate, a carer support worker, another carer or a mental health professional.

The carer's plan is about describing what the carer's needs are and what realistic and achievable actions can be taken and by whom to do something about meeting those needs.

Need identified by carer	Action	Action by whom and by when
The following summarise the areas looked at: **Caregiving tasks** **How to get help and advice** **Information about care workers** **Information about mental illness** **Involvement in planning of treatment and care** **Support for carers** **Relationships with the person you care for** **Family and friends** **Money** **Your well-being** **Stigma and discrimination** **Risk and safety** **Choice of care** **Other issues**		

Attach a copy of this Carer's Plan to the Patient's Assessment and CPA forms as appropriate.

Appendix 4.3
Patient's and carer's leaflet

Patient's and Carer's Discharge Standards

Patients being discharged from hospital have the right:

1. To full information on their diagnosis and the assessment of their health and social needs in preparation for discharge.
2. To be fully involved in planning their own discharge, together with a relative, carer or friend as appropriate.
3. For the discharge plan to start on or before admission where possible.
4. To full information on the services available in the community relevant to their care.
5. To full information on short- or long-term nursing or residential care, including financial implications.
6. To be given an appropriate contact number where they can get help or advice on discharge.
7. To be given a clear, legible discharge letter detailing the support services provided for them (where appropriate).
8. To full information on health authority eligibility criteria for continuing care.
9. The discharge planning team to be available as a point of contact to offer support and advice to patients, carers, statutory and voluntary agencies.
10. Information on advocacy support.
11. To have access to the trust complaints procedure and any complaint regarding their discharge arrangements investigated and a full explanation given.
12. If still not satisfied, then be given access to the health service commissioner.

Source: Adapted from the work of the liaison nurses, York Health Services Trust.

5. Co-ordinating the patient journey

The *key principles* underpinning this aspect of effective discharge and transfer of care policy are:

- Discharge is a process and not an isolated event. It has to be planned for at the earliest opportunity between the primary, hospital and social care organisations, ensuring that patients and their carer(s) understand and are able to contribute to care planning decisions as appropriate.
- The process of discharge planning should be co-ordinated by a named person who has responsibility for co-ordinating all stages of the patient's progress. This involves liaison with the pre-admission case co-ordinator in the community at the earliest opportunity and the transfer of those responsibilities, on discharge.
- Staff should work within a framework of integrated multidisciplinary and multi-agency team working to manage all aspects of the discharge process.

5.1 An overview of the key issues

The patient journey starts in the community where proactive early intervention and preventative measures can avoid the need for emergency admission to hospital for some people. The importance of developing preventative care and support for people judged to be at risk is widely recognised and a key objective of intermediate care policy. The Audit Commission for example has identified the potential of active gatekeeping of patients in Accident and Emergency (A&E) departments to screen out those who do not need to be admitted. This can only be effective when a full range of services are available to meet needs.[1]

A number of innovative schemes, including rapid response teams, have been developed to provide support across the health and social care boundary. Others provide intermediate care, interim/transitional care and supported housing. Many of these services provide early intervention, to avoid unnecessary hospital admission and supported early discharge. These are discussed in more detail in Section 6.

Once admitted to hospital individuals and their carer(s) often feel disempowered, unable to put their point across, unsure about what is happening.[2] Early engagement and identification of their worries, concerns and aspirations are critical if individuals are to be helped to reach their goals. A protracted length of stay brings with it inherent risks of infection, loss of independence and confidence. The important contribution made by carers can be neglected and their concerns marginalised, leading to unexpected difficulties later in the process.[3]

The *NHS plan*[4] identified the need to simplify and clarify the assessment processes operating within the NHS and between the NHS and councils with social services responsibility. Too often there is lack of compatibility between the systems and people with complex needs find themselves undergoing multiple, and unco-ordinated assessments.[5]

A single assessment process (SAP) is being introduced for older people to resolve these long-standing problems. Practitioners are advised to find out about their local implementation plans through their managers. Detailed information about the SAP is provided on the website www.doh.gov.uk/scg/sap.

Many of the delays that occur in discharging patients are predictable. This points to factors at different stages of the patient's journey that affect delay. Many of these relate to communication and co-ordination between health and social care and between primary and secondary care. Others are concerned with internal hospital systems.[6] This underlines the importance of starting discharge planning at the earliest opportunity following admission in order to plan for, and resolve, problems before they impact on patient care and length of stay.

The pressure to discharge/transfer patients and release beds and a trend to shorter lengths of stay means that assessment and discharge planning, by necessity, is concentrated into a shorter time scale. Effective and efficient discharge practices are necessary to ensure that premature discharge is avoided and an increase in re-admissions prevented.[7]

Premature discharge typically leaves the patient with some unmet needs and poorly prepared for home. Carers have reported that inappropriate assumptions are made about their ability to cope. Preparation to ensure medicines compliance, chronic disease management and the provision of, and ability to use, equipment are some aspects of helping the individual prepare for life outside of hospital that require sufficient time and attention.[8]

In recent years, owing to weak market conditions, there has been a notable reduction in the number of care homes. There are also increasingly major capacity issues in home care services that, in some areas, have restricted the availability and choice of homes and other services to individuals.[9] This will be covered in more detail in Section 7.

The aims of effective discharge co-ordination are to:

- promote good clinical outcomes;
- promote good care management of individuals and establish care pathways across service boundaries;
- ensure that the carer has a choice about caring and that, if they choose to care, they are supported to do so in a way that promotes their health and well being;
- provide effective and efficient systems for inter-professional referral, treatment and support.

5.1.1 Effective discharge practice

This is underpinned by:

- Inter-agency policy/agreements that deliver effective and flexible discharge care pathways (see Section 3).
- Pre-admission and admission assessment processes ensure individuals are directed to the right care/service and the needs of the carer are taken into account

- Having and using a named person at ward level who is responsible for proactively co-ordinating the patients' journey.
- Having a clear communication strategy for each patient that takes account of their needs, abilities and means of communication.
- The identification of individuals who have additional health and social care discharge needs on admission or at the earliest opportunity following admission.
- Discharge planning takes place over seven days a week.
- Effective patient-centred multidisciplinary teamwork that ensures the patient receives continuity of care as they are transferred from one setting to another.
- Efficient internal referral processes, treatment and rehabilitative services.
- Well organised transport, medication, home support and equipment provision to support discharge.

5.2 The patient journey

5.2.1 The role and purpose of pre-admission screening

Pre-admission screening should be routine for all elective admissions. This is the ideal time to identify, and plan for, any additional health and social care needs on discharge, and to ensure the stay in hospital is kept to the shortest time necessary for a good recovery. This period of preparation helps patients and their families understand how they can help themselves and plan for their return home. This can include arrangements for the provision of equipment and/or adaptations to the home before, or during, admission.

For all other admissions pre-admission assessment provides an opportunity to distinguish between emergency and non-emergency admissions and to decide whether admission for acute care or an alternative course of action is necessary. Pre-admission assessment can take place either as a fast track out-patient appointment, in a day hospital or on presentation to an A&E Department or Medical Assessment Unit.

Not all patients are suitable for pre-admission screening; some will be too ill and need urgent and immediate admission and medical or surgical treatment.

Pre-admission assessment/screening can work effectively as a gatekeeper to acute care when primary and secondary care clinicians and managers and social services mangers agree protocols and practices to ensure:

- the appropriateness of GP referral to acute care;
- effective in-patient selection for those who will need acute hospital care;
- the development of integrated care pathways for specific chronic conditions;

- the right capacity and organisation of diagnostic and treatment facilities
- fast track access to intermediate care and transitional services outside the acute sector (see Section 6).

5.3 Pre-admission assessment

The initial medical assessment will indicate whether the patient's condition makes care options, other than an acute hospital admission, viable and if so, assessment of the health and social care needs of individuals will be required very quickly. When an individual is referred for admission, and/or presents at an A&E department, it is usually in response to a crisis in their lives. The assessment process should identify the reasons for the admission, including any social care issues and any recent changes in these. It is important to find the underlying cause of the problems that will need to be addressed to avoid a future referral and/or avoidable deterioration in health.

The use of systematic pre-admission/admission assessment processes will identify problems that require additional planning before the patient can return home and if admitted enable patients to be targeted for complex discharge planning.[9] The discharge care pathway is described in Figure 5.1 (see page 56).

It is important that there is a systematic assessment of the individual's recent functional ability as well as that at the time of the pre-admission assessment. There are problems that might be overlooked by traditional nursing and medical assessment, such as impairments in cognitive ability, continence and/or mobility, which need to be recognised as new or long standing. Assessment of the home environment and support networks also needs to be explored.

Departments undertaking admission assessment should ensure that procedures are in place to systematically identify individuals who may have additional health and social care needs. If the patient's medical condition allows the following basic areas should be explored to give an indication of possible problems requiring careful consideration:

- The individual's views on how well they were coping with activities of daily living.
- The carer's worries and concerns about how he or she is coping.
- Any issues in the home environment.
- Medication compliance.

Pre-admission assessment and screening also helps to identify vulnerable individuals who need specialist assessment and services for: falls prevention; chronic obstructive airways disease; intermediate care; or dementia. Care pathways should be in place to enable patient referral to these services.

Once additional needs have been identified a named individual will need to take the lead role in obtaining/requesting the relevant information. This will require contact with other services providing care to the individual in the community. These could include primary care and community health teams, care home and home care providers, sheltered housing wardens, sensory impairment, community mental health and learning disability teams.

The framework for assessment will be determined by the presenting needs of the individual. Older people will be assessed using the single assessment process (SAP), '*a process whereby the needs of an individual are identified and their impact on daily living and quality of life is evaluated.*'

The SAP, contained within the *National service framework for older people,*[10] is in the process of being implementated and provides guidance on how the depth and scale of assessment is kept in proportion to older people's needs. Agencies should not duplicate each others assessments, and professionals need to contribute to these assessments in the most effective way. The SAP was developed specifically for older people and has not been tested for other care groups.

When assessing the presenting needs and circumstances of other adults, reference should be made to the particular assessment and care planning guidelines for those care groups. *The Fair access to care services*[11] provides guidance on such an assessment and is helpful in balancing the different perceptions of risk and in countering a tendency to exclude the individual's own priorities in favour of an emphasis on health and safety issues.

These assessment processes need to consider risk. The purpose of risk assessment is to consider all the factors in patients' abilities to manage their own care, the danger they pose to themselves and others and a prediction about how they will respond to treatment and rehabilitation. It is central to any decision-making that surrounds care planning and future care options.

The assessment of risk must involve patients in a meaningful way and in circumstances where patients cannot represent themselves, the next of kin, and/or an advocate, should be involved. Advocates might enable views that differ from the carers' views to be heard. Carer(s) and relatives are often present at this time to contribute to the assessment.

Research suggests that different professions tend to perceive risk factors in different ways. At times these may be in conflict with the patient's own perception of risk and what they consider to be an acceptable risk, especially if it means that they can return to their desired destination.[9]

The construction and negotiation of risk management requires multidisciplinary team involvement in order to ensure that all the different perspectives are considered and that a way forward is agreed between all those concerned.

Medication compliance is an important factor in any risk assessment process to determine a person's ability to manage at home. The use of medication is increasing in response to evidence on the effective management of chronic disease, and many patients will be taking a number of different medicines to manage their condition. This is particularly evident in the older age groups who suffer from a number of chronic conditions. Mental and physical impairment is also common in this age group. The risk of drug interaction increases with additional medications and whilst in hospital it is likely that a familiar medication pattern will have changed.[12] More detail on medication management is provided in Appendix 5.1.

Patients may also have responsibilities such as being the parent of young children or as a carer of someone who has a disability and who is unable to live independently. It is important to identify whether an adult has dependent children and to ensure that arrangements are in place for their care during the period of admission. If the child is the carer of an adult with a chronic illness or disability, the child's own needs for support must be addressed. It is vital that every effort is made to ensure that the family has sufficient services to ensure that children are not left with unacceptable caring responsibilities that affect their welfare, education or development. In addition, patients can also be carers, and it is important to ensure that if they are caring for someone that they have the right services upon discharge, to ensure that they can look after their own needs, as well as the person they are caring for.

The assessment of a carer's needs is separate from the assessment of the patient. Care must be taken to discuss with carers their concerns and make arrangements for a full assessment where appropriate. Consideration at this stage should include any risks to their own health, risk of harm to the carer and risk of loss of employment as well as helping carers to care with support. This will also include factors that contribute to the patient's risk assessment.

In a case where immediate admission to acute care is required the assessment should follow at the earliest opportunity after admission to the ward. The assessment process should continue once any immediate medical needs have been dealt with on transfer to intermediate care or rapid response services in circumstances where there is no doubt that the patient does not require an acute admission. Pre-admission assessment services should have fast access to intermediate and transitional care services so that patients can be transferred, without delay, to continue with their assessment and treatment.

5.3.1 Information flows between organisations and services

It is the responsibility of the referrer to ensure any previous assessment and care planning information accompanies the individual, or is transferred as soon a possible. In the case of older people it is anticipated that the flow of information will improve as a result of implementation of the SAP. Interim measures should be in place to ensure that information comes with the patient.

Using electronic methods of data transfer can speed up communication. In the pre-admission stage a decision on the right care pathway is required quickly. Good communication between agencies has been achieved when A&E staff have had immediate access to care management information and advice. Inter-agency agreements can enable the person's own community care provider to keep the care package open while awaiting the completion and evaluation of the assessment and a decision to admit or to return home is made.

It has been shown that when inter-agency agreements are in place, quick and short-term changes to the care package can be made in A&E and medical assessment units, enabling patients to return home quickly. The individual's care manager at the earliest opportunity can then review the care package.

The integration of therapy, particularly occupational therapy, care management and community mental health nurses into A&E and medical assessment units has brought significant benefits in ensuring individuals receive the right assessment and care. Regular input from discharge planning teams similarly promotes integrated working and increases the awareness of hospital staff of the options and constraints available for individual patients. Many different models have emerged and details are available on the Department of Health's website: www.doh.gov, under Change Agent Team. The role of discharge planning teams is described later in this section.

5.3.2 Pre-admission checklist

Allocate a named individual to undertake the initial screen/risk assessment to:

- gather and record information from the patient;

- liaise with the social services care manager and primary care to access SAP information, where appropriate;
- access home drugs regime;
- investigate the individual's housing situation;
- identify who is the main carer and discuss with them their own needs;
- discuss with the carer their needs;
- provide the patient and the carer with information and check they understand what is happening and the most likely next steps.

Once the preliminary assessment information has been gathered a decision on the care options is required to enable fast transfer of the patient, where immediate acute admission is not the first choice. The medical team, in collaboration with the multidisciplinary team, will:

- assess how risks are viewed by individuals and their carers (use advocacy and interpreting services if appropriate in order to facilitate a shared approach to care);
- identify and discuss with the patient the possible care options and verify their home support systems;
- narrow down care options and refer to services that will meet need and/or provide additional information
- agree with the patient, and with the carer, the next steps and provide information;
- finalise care plan and arrange transfer or discharge;
- check that information of financial benefits has been given and understood.

5.3.3 Action plan

Acute trusts should establish multidisciplinary pre-admission clinics for elective admissions.

Managers and clinicians of A&E, medical assessment units and rapid assessment clinics, in conjunction with managers of social services, should agree a common approach to the initial screening of patients to identify issues that may affect their return home. As part of this they will want to consider:

- Develop a system where the units have immediate access to care management information and to GP and community health records seven days a week and during evenings.
- Agree joint documentation.
- Agree inter-agency protocols that enable funded care packages to remain open while the assessment is completed and short-term enhanced packages of care provided.

- Ensure A&E and medical assessment units have fast access to occupational therapy and care management support to ensure holistic assessment of individuals and fast referral to more appropriate services.
- Agree how the multidisciplinary team can access transitional support and intermediate care services for individuals and how medical support for these referrals should be provided.
- Ensure staff have access to interpreting and advocacy services.
- Have access to a range of information in appropriate formats to support the patient and the carer.
- Develop referral protocols to access specialist advice for people suffering from a confused state and/or dementia or learning disability.
- Establish and agree protocols for immediate access to simple equipment and minor aids.

5.3.4 Practical examples

- The development of a single point of access for GPs and A&E to refer to community based intermediate and rapid response services. A screening assessment is undertaken over the phone and the single point of access coordinates the response. Inappropriate referrals are referred to the right service following preliminary assessment.
- Skill mix of community teams are able to assess for community nursing and/or care management to ensure services are provided without delay in A&E/medical assessment units.
- The use of standardised joint documentation in A&E and medical assessment units including a section to identify complexity.

5.4 Admission to the ward

On admission to the ward a named individual from the ward staff should be identified to co-ordinate all stages of the patient journey to proactively support and facilitate the work of the multidisciplinary team in delivering the best outcomes for the patient and guide them through the system to receive what they need, when they need it.[6] This role, henceforth referred to as the ward-based care co-ordinator, should focus on the needs of patients who have been identified as requiring additional support in discharge planning. The discharge care pathway is described in Figure 5.1 (see page 56).

If the patient is transferred to another ward it is the responsibility of the ward-based care co-ordinator to provide a formal transfer of responsibility.

5.4.1 What is the role of a ward-based care co-ordinator?

This is an important, highly skilled role and requires an experienced practitioner who has a good understanding of discharge planning. The role is usually undertaken by nurses; however, it may be appropriate in a transitional or rehabilitation service for a therapist or social worker to be the care co-ordinator.

When the ward-based care co-ordinator is off duty an associate care co-ordinator, or team member, should provide cover to ensure continuity of care planning. Team working, with responsibility for specific beds, is one way of providing continuity. Night staff can provide additional support to this team approach as they are often on duty when carers and relatives visit in the evening. It is important that, whatever the model, to ensure all concerned are clear about who takes the lead.

The ward-based care co-ordinator has the lead responsibility for co-ordinating all aspects of the patient's care including discharge/transfer planning. This seven days a week role requires a proactive approach to ensure the plan is progressing smoothly and to take immediate action to address problems in support of the multidisciplinary team.[13]

The name of the ward-based care co-ordinator should be clear to all those involved in the patient's care and clearly documented in the patient's notes. Patients, their carers and/or relatives should be aware who this individual is, and how to contact him or her.

If at any time the ward-based care co-ordinator changes, the patient and his or her main carer/relative should be informed immediately and a record made in the patient documentation, informing all other members of the multidisciplinary team of the change.

Ideally, all communication with the patient should be recorded in one set of documentation.

5.4.2 Care co-ordinator key tasks

- Co-ordinating patient assessment, care planning and daily review of the care pathway.
- To discuss with the patient a potential transfer/discharge date usually within 24 hours of admission and recorded in the patient's notes.
- Ensure that timely referrals are made, results are received and any delays are followed up.
- Identify, involve and inform the patient about all aspects of care planning, ensuring that the special needs of young carers are identified.
- Engage the carer and make arrangements for carer assessment if appropriate. Make arrangements to see the carer separately regarding their own needs.
- Keep the patient's documentation up-to-date.
- Liaise with and work as an integral member of the multidisciplinary team and care management services.
- Liaise with specialist nursing service and other specialist services as appropriate.
- Finalise the transfer/discharge arrangements 48 hours before discharge and confirm with the patient and carer/family.
- On day of transfer/discharge ensure the patient's condition remains as expected and confirm follow up arrangements.

A transfer/discharge checklist is provided in Appendix 5.2.

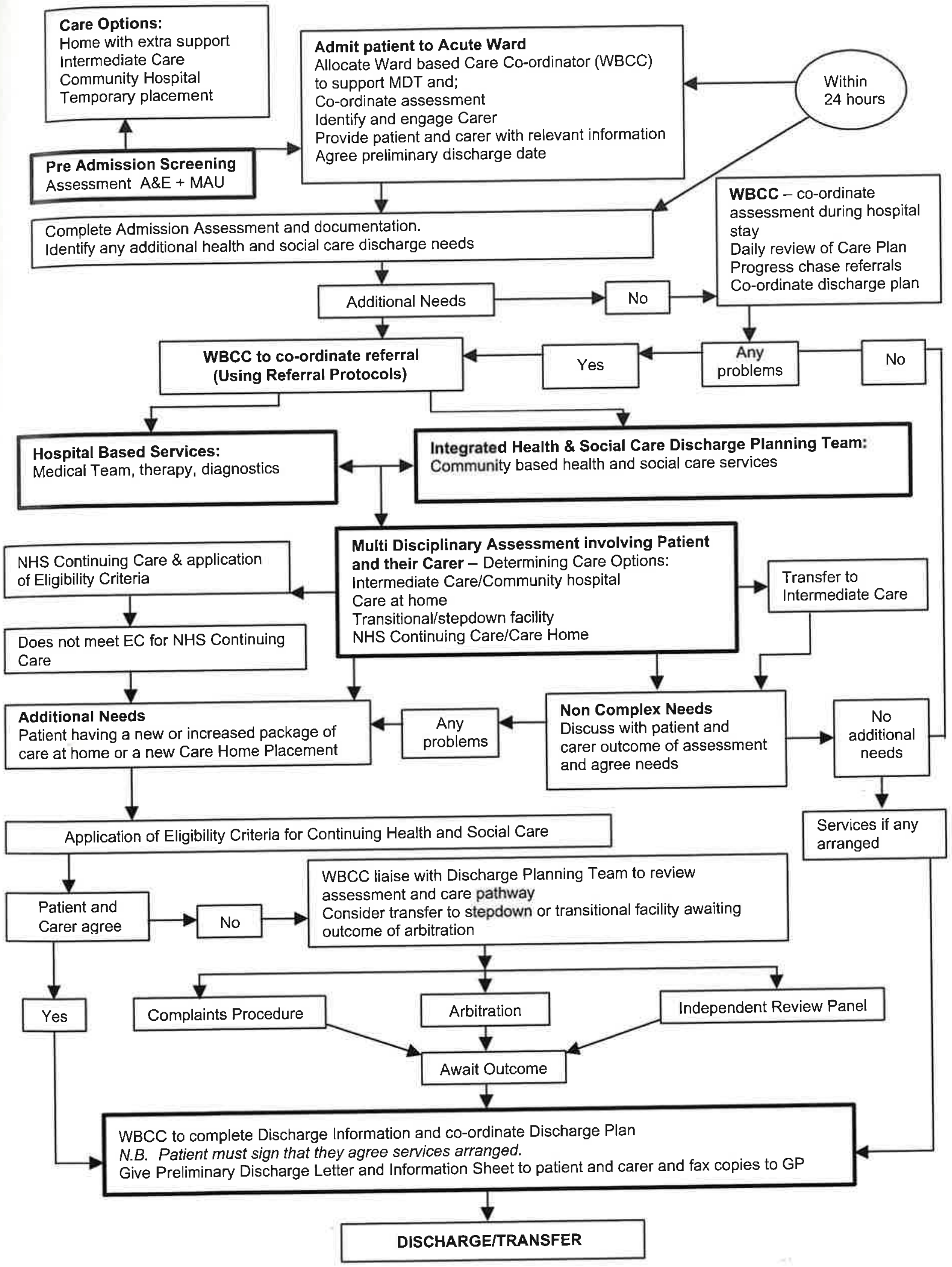


Figure 5.1. Hospital discharge pathway. Adapted from the Hospital Discharge Pathway developed by the liaison nurses York Health Services Trust.

5.4.3 Decision to discharge

A decision that a patient is medically fit for discharge can only be made by the patient's consultant (or by someone to whom the consultant has delegated his/her authority) or by another doctor who is responsible for the care of the patient. Patients, who have both health and social care needs, must only be discharged when they are clinically fit. This is a decision made by the multidisciplinary team when considering all the factors, which will include the relative safety of remaining in hospital or being elsewhere and the patient's and carer's view of these risks. It is also important to include the carer as part of the team as they will have expertise regarding the patient's home environment.

Self-discharge or discharge against medical advice may fall into one of the following categories. The patient:

- understands the risks they are taking in discharging themselves;
- is not competent to understand the risks associated with discharge due to his or her medical condition;
- is not competent to understand the risks associated with discharge due to mental health problems.

The discharge policy must set out the procedure to be followed by the ward-based care co-ordinator in such circumstances.

5.4.4 Nurse-led discharge

In the *NHS plan* the Chief Nursing Officer identified 10 key roles for nurses, one being, 'to admit and discharge patients for specific conditions using agreed protocols'.[4]

The implementation of nurse-led discharge is already occurring in some trusts. Successful nurse discharge requires the active involvement of senior nurses and medical staff. Where nurse-led discharge is in place it has started with straightforward surgical procedures and been underpinned by the development of local protocols agreed between the ward team. In these areas nurse-led discharge is now being systematically extended to other surgical and medical conditions. Further information is available in the Department of Health publication *Developing key roles for nurses and midwives – guide for managers*. This can be found on the website: www.doh.gov/newrolesfornurses.

The role of ward-based care co-ordinator could be enhanced to include nurse-led discharge.

5.4.5 Supporting early discharge and avoiding re-admission

Many patients with long standing chronic conditions are readmitted to hospital several times each year.

Exacerbation of chronic obstructive airways disease is one of the most common reasons for emergency admissions to hospital.[14] Several clinical trials have concluded that home supported discharge is well tolerated, safe and an economic alternative to hospital care. These schemes also provide an alternative to hospital admission for some patients when schemes are provided across the primary acute interface and work within agreed clinical protocols.[15]

Other presentations that need additional support over and above what the acute hospital is able to provide are described in Appendix 5.2.

The role of transitional and intermediate care is described fully in Section 6.

5.5 Equipment provision

The role and provision of equipment is described in more detail in Appendix 5.3. Practitioners are advised to keep up to date with the Integrating Community Equipment agenda through the ICES website: www.icesdoh.org.

5.6 Discharge lounges

The development of a *discharge lounge* can assist the co-ordination of the final stages of discharge, such as transport and medication. The lounge provides a safe and pleasant environment for patients who no longer need their hospital bed but are awaiting the completion of various practical arrangements before they can be fully discharged. This is described in Appendix 5.4.

5.7 Transport

Transport arrangements are important when planning a discharge. A range of options for meeting a patient's transport needs in a timely and suitable way are discussed in more detail in Appendix 3.3.

5.8 Action plan

Agree the senior management lead for implementing care co-ordination across the hospital.

Agree the model of care to ensure continuity of co-ordination and a proactive approach seven days a week through team or associate roles. As part of this, consider:

- Agree contingency plans for sickness and agency cover.
- Develop a competency framework for ward-based care co-ordinators.
- Identify suitable staff to undertake the role of care co-ordinator. Provide regular training and supervision for the role. Involve the hospital discharge team and patients and carer representatives in development of the training programme.
- Ensure ward-based care co-ordinator has access to comprehensive patient and carer information.

- Develop one set of documentation to be used by all staff involved, which is kept on the ward.
- Clarify how the Patient Advisory and Liaison Service and advocacy support can assist the role.

5.9 Practical examples

- The role of the modern matron should include responsibility for nurse leadership in discharge planning.
- The ward-based care co-odinator role is provided through a team approach whereby a senior staff nurse supervises more junior staff and ensures the role is a proactive one.
- Care pathways are developed with supporting documentation. Documentation is colour coded to assist practitioners to find specific discharge information easily.

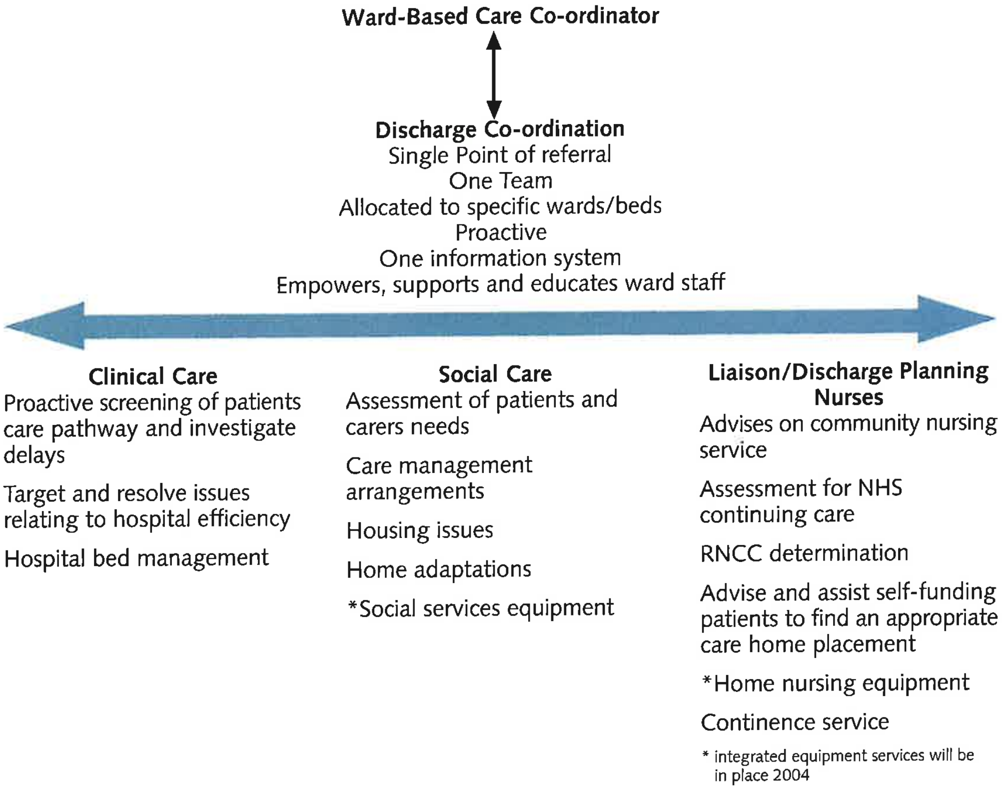
5.10 Multidisciplinary and inter-agency teamwork

There is consistent evidence to suggest that best practice in hospital discharge involves multidisciplinary teamwork to actively manage all aspects of the discharge process.[16] The Health Select Committee went further and recommended that the leader of the team should be jointly appointed by the NHS and local authorities with social services responsibilities.[15] In the context of hospital discharge planning this is a way of organising the team around a group of patients rather than in professional groups.

5.10.1 Developing discharge planning teams

A discharge planning team is a group of professionals and support workers who work together to provide a service to an individual who requires community health and social care services on leaving hospital. They work to agreed objectives that are interdependent of each other. They have a clear understanding of each other's roles and there is a free flow of communication and information between team members. They work to a single care plan and to one set of documentation and support the ward-based care co-ordinator and the wider multidisciplinary team in caring for the patient.

There is some evidence that when a discharge planning team is organised around beds/wards individual team members and ward staff build up a rapport and trust that facilitates joint working and patient/carer engagement. It is also a more efficient use of team members' time. The multidisciplinary team working to provide clinical care to the patient at ward level may consist of medical, nursing, therapy and pharmacy staff at any one time and collaborative working is essential to achieve good patient outcomes.[16] There is an opportunity to consider how the team can reduce any overlap of roles, although the disciplines will remain professionally distinct there will be some role blurring or blending, thus allowing flexibility in meeting an individual's needs.



Ward-Based Care Co-ordinator

Discharge Co-ordination
Single Point of referral
One Team
Allocated to specific wards/beds
Proactive
One information system
Empowers, supports and educates ward staff

Clinical Care

Proactive screening of patients care pathway and investigate delays

Target and resolve issues relating to hospital efficiency

Hospital bed management

Social Care

Assessment of patients and carers needs

Care management arrangements

Housing issues

Home adaptations

*Social services equipment

Liaison/Discharge Planning Nurses

Advises on community nursing service

Assessment for NHS continuing care

RNCC determination

Advise and assist self-funding patients to find an appropriate care home placement

*Home nursing equipment

Continence service

* integrated equipment services will be in place 2004

Figure 5.2. The discharge planning team.

The patient may be in receipt of care and treatment from a number of different teams at any one time. It will be essential that the ward-based care co-ordinator liaises effectively with appropriate personnel to co-ordinate the sequence of decisions and events in the care plan, so that the planning progresses smoothly and any problems are identified and dealt with. The combination of referral protocols and the frequency with which team members work together has been shown to improve the appropriateness of referrals and improve care pathways for patients.[15]

In care of the elderly services team co-ordination is frequently organised through routine weekly multidisciplinary team meetings. This model of care-planning works best when it is organised around wards and beds. Pressure on hospital services has resulted in patients being out-posted to other wards where multidisciplinary working may not be so well developed. Such experiences are associated with an extended length of stay for these patients.[17]

In order to reduce duplication and to support staff in managing their workload the discharge planning team should work to agreed protocols for referral and standard response times if delays are to be avoided. This may involve integrating some elements of health and social care discharge planning roles and using generic support staff to take on the more routine administrative functions as described above.

As part of the ward team, the discharge planning team has invaluable experience and understanding of community services. They have a knowledge of the care management system for individuals in the community and the available resources. This information can help ward-based staff understand the facilities available to support discharge and play an important advisory role in determining the care options available for an individual. It is important to ensure that the independent sector providers are made to feel part of the team when planning for ongoing health and social care needs.

The local geography and configuration of district nursing and care management services to GP practices will influence the most effective way of providing support to the discharge planning process. Two models for consideration are:

- hospital based outreach teams who have community experience, with staff allocated to specific wards/beds to improve continuity at ward level;
- community-based in-reach teams who go into the hospital.

A good team has:

- a well-developed understanding of the key roles and responsibilities of those involved in rehabilitation and discharge planning;
- a comprehensive knowledge of the care options available, the referral processes and criteria for admission to those services;
- information on what services are provided in the patient's own locality by the independent sector and housing organisations;
- the support of generic staff who take on the more routine administrative functions to enable the skills and experience of the team to be targeted effectively. New roles can be developed such as homefinder posts;
- excellent communication and problem solving skills;
- the ability to work proactively to ensure patients receive appropriate care in the right setting.

5.10.2 Action steps

Senior managers from local authorities with social services responsibilities, primary care trusts and acute trusts need to consider:

- Jointly commission an integrated hospital discharge team.
- Agree which agency will have the lead responsibility for managing the team.
- Appoint a project manager/team leader to establish an integrated approach.
- Provide team building opportunities and joint training to enable a greater understanding of respective roles and responsibilities contribution and joint working.
- Consider locating the team together.
- Develop agreements to share both electronic and manual information.
- Agree how to implement and monitor the single assessment process and use integrated care pathways.

- Analyse where the roles overlap and agree the skill mix of core roles and generic support staff to free-up skilled staff to focus their skills and resources effectively.
- Develop an education/training programme for staff in discharge planning to include working with carers.

5.10.3 Practical examples

- Use of night staff/site co-ordinators to screen patient documentation to identify delays and help provide a 24-hour approach to discharge/transfer planning.
- Implementation plans for the single assessment process, include interface issues to improve continuity between community and acute services to reduce red tape.
- A structured out-of-hours appointment system so that carers and relatives can meet with the professionals to discuss and plan care.
- Co-location with the team of independent sector schemes such as 'Home from Hospital' and 'Handyman' schemes and carers support.
- The role of pharmacy technicians has been extended to provide medication advice and training to patients and carers and liaise with primary care to follow up patients at risk from non-medication compliance. This has been shown to improve medication compliance.

5.11 References

1. Audit Commission (2000). *Inpatient admissions and bed management in NHS acute hospital.* London: The Stationery Office.

2. Preston, C., Cheater, F., Baker, R. and Hearnshaw, H. (1999). Left in limbo: patient's views on care across the primary/secondary interface. *Quality in Health Care* **8**: 16-21.

3. National Audit Office (2000). *The management and control of hospital acquired infection.* London: The Stationery Office.

4. Department of Health (2000). *The NHS plan: a plan for investment, a plan for reform.* London: Department of Health.

5. Department of Health (2001). *NHS funded nursing care-practice guide and workbook.* London: Department of Health.

6. House of Commons Health Committee Delayed Discharges (2001-02). Vol. 1. London: The Stationery Office.

7. The Royal Commission on Long Term Care (1999). *With respect to old age – rights and responsibilities.* London: The Stationery Office.

8. Department of Health (2001). *Building capacity and partnership in care.* London: Department of Health.

9. McMillan, M.S. (1994). Hospital staff's perception of risk associated with the discharge of elderly patients from acute hospital. Journal of Advanced Nursing **19**(2): 249-256.

10. Department of Health (2001). *The national service framework for older people.* London: Department of Health.

11. Department of Health (2002). *Fair access to care services (FACS).* London: Department of Health.

12. Pickrell, L., Duggan, C. and Dhillon, S. (2001). From hospital admission to discharge: an exploratory study to evaluate seamless care. *Pharmaceutical Journal* **267:** 650–653.

13. NHS Modernisation Agency (2001). *Improving the flow of emergency admissions.* London: NHS Modernisation Agency.

14. Swarska, E., Cohen, G., Swarska, K.M. *et al.* (2000). Randomised controlled trial of supported discharge in patients with exacerbations of chronic obstructive airways disease. *Thorax* **55:** 907–912.

15. Audit Commission (2002). *Integrated services for older people.* London: The Stationery Office.

16. Borill, C., Carlatta, J., Carter, J. *et al.* (2001). *Team working and effectiveness in health care. Aston Centre for Health Service Origanisation Research.* Aston: ACHSOR.

17. Audit Commission (2000). *Inpatient admissions and bed management in NHS acute hospitals.* London: The Stationery Office.

Appendix 5.1
Medicines management

A5.1.1 Why is it important?

Medicines management plays an important role in preparing patients and their carers for transfer/discharge, which has an impact on the recovery and/or maintenance of their conditions following discharge. The use of medication is increasing and many patients will be taking a number of different medicines, quite appropriately, to manage their condition. This is particularly evident in the older age group who may suffer from a number of chronic diseases. Mental and physical impairment are common in this age group. The risk of drug interactions increases with additional medication. A high proportion of hospital admissions and re-admissions, quoted as between 5% and 17%, are due to adverse reactions to medicines or incorrect medicine taking.[1,2]

Specific targets for medication review were set out in the *National service framework for older people*:

- Annual medication review is a target for all people over 75 years, and those taking four or more medicines should have a six-monthly review. To meet this target primary and hospital practitioners will need to work together.
- All hospitals are to establish one stop dispensing for discharge schemes and where appropriate, self-administration schemes for medicines for older people.

Whilst a patient is in hospital it is likely that a familiar medication pattern will be changed. In order to take the changed medicines as the prescriber intended, the patient and/or their carer needs to understand the rationale for the medication regime as well as physically manage to take the medicines. The GP similarly needs to have up-to-date information so that he/she can continue the revised medication plan when the patient is home. Taking medication in accordance with the prescriber's instructions is an important factor in any assessment process to determine a person's ability to manage at home. The organisation of 'take-home drugs' can also be a reason for delay when a person is ready for transfer/discharge.[3]

A5.1.2 What are we trying to achieve?

That the patient is given and takes the correct medicines in the correct doses at the right time, both when in hospital and after discharge.

Crucial to this is continuity of medicines management between primary and acute care:

- The success of the acute episode, any continued rehabilitation and recuperation of the patient, the avoidance of readmission and effective palliative care.

- Ensure the patient does not suffer from illness caused by excessive, inappropriate, or inadequate consumption of medicines.

This can only be achieved when services are designed around patients, their individual needs and take account of pre admission care, the hospital stay and post discharge care.

A5.1.3 Some common problems

- Information on patients' medicines received by the hospital may not be fully accurate and the wrong prescriptions may be continued during the hospital stay and on discharge.
- Patient's home medication is destroyed when they are admitted to hospital.
- Junior doctor delays in writing up 'take-home drugs' so medicines are not ready when patient is ready to leave.
- Patients view their hospital medication and home medication as different and may take both, thus taking double doses of some medicines.
- When home, patients inappropriately revert to their pre-admission medication.
- Repeat GP computer generated prescriptions following discharge are not always up to date with the revised hospital medication plan.
- GP discharge letter arrives at practice after repeat prescription due.
- Discharge letter does not give full information: GP is not clear on the exact changes in medication that have been made by the hospital.
- Lack of communication between hospital and patient's community pharmacist.
- Disagreements on appropriate prescribing between hospital doctors and GPs leading to switching of patients' drugs after discharge, e.g. to cheaper or formulary drugs.

A5.1.4 How can we redesign services around patients?

The assessment and care planning processes must take account of both the medication and the patient's ability to take the medicine. It should include the assessment and care planning of any medication that prepares the patient and carer for transfer/discharge. This is particularly important where a patient has complex needs as they are known to be at a higher risk of medication discrepancies. The assessment also needs to include an assessment of whether the patient is able to take the medicines at home unaided or whether assistance is required in the form of either personal (i.e. a carer is needed to give or assist with giving the medicines) or mechanical (e.g. large type face for poorly-sighted patients).

The process of ensuring that the patient gets the right medicines on discharge needs to begin at admission to ensure that the medication record is accurate and to avoid incorrect medicines/doses being given in hospital and this being perpetuated on discharge. The early identification of medicines issues can ensure patients receive targeted help to overcome problems. In many areas the use of pharmacists and an extended role for pharmacy technicians has facilitated a patient/carer centred approach. Pharmacists tend to produce more complete medication histories when compared with junior doctors, and they can make a valuable contribution to improve patient outcomes.[4,5]

The pharmacist has the clinical knowledge to optimise the medication regime and develop a medication plan, while the pharmacy technician can support the plan, by working on the practical aspects which improve compliance, where appropriate, in liaison with primary care and the community pharmacist. This is most effective when ward-based as part of the core multidisciplinary team for a group of patients.

In some areas the role of pharmacists and technicians has been developed to provide continuity of care between the hospital and home. Hospital and GP-based pharmacists have collaborated for patients who are deemed to be at high risk from non-compliance. The community pharmacist provides a follow-up visit soon after discharge and at the same time that a new GP prescription is due. This approach can help resolve any misunderstanding of the correct medication to take and reinforce medication compliance. Further follow-up visits are arranged according to the patient's needs.

A5.1.5 Patient centred schemes

Following publication in 2000 of *Pharmacy in the future, implementing the NHS plan*, other approaches have been recommended that move dispensing from a pharmacy-based, to a ward-based and patient focused service:

- One-stop dispensing.[6]
- Use of patient's own drugs.
- Self-administration schemes.

One-stop dispensing refers to the practice of combining in-patient and discharge dispensing into a single supply, labeled for discharge. Medicines are increasingly provided in individual patient packs, which means that typically a patient will go home with several weeks supply.

Patient's own drugs involve the patient bringing their medicines into hospital with them where the medicines are assessed, and accepted or not, according to the local protocol for quality control. These drugs are used during the in-patient stay and on discharge.

Self-administration relies on the patient's ability to self-administer and of the education and supervision required for them to become competent to self-administer.

These schemes require practical considerations of storage and work best when the patient has his or her own lockable medicines cabinet and the key is kept by the nurse who administers medicines.

All these schemes require careful project management during the planning stage and at implementation on a practical level within the hospital and to gain agreement with primary care on the changes to prescribing and on the communication processes.

A5.1.6 Action plan

- Agree a multidisciplinary approach across primary and acute care to review and plan change towards a patient centered approach.
- Consider how the role of pharmacists and pharmacy technicians can be used in the assessment and care planning of patients with complex needs.
- Ensure the assessment process for discharge includes an assessment of the patient's capability to manage the medicines at home.
- Review communication processes between acute and primary care to ensure follow-up of patients at high risk from medication non-compliance including the role of independent community pharmacists.
- Review the role of junior doctors and pharmacists in taking medication histories on admission and writing up TTAs (drugs to take away).
- Agree protocols with pharmacy for the use of discharge lounges.
- Use the media to publicise changes in practice, in particular patient's own drugs schemes, which require patients to bring their medication into hospital.

A5.1.7 Practical examples

- The pharmacist works closely with staff on assessment units to take a detailed medication history and develop a medication plan. The technician liaises with the GP practice and community pharmacist to access all relevant information and then carry out the medication plan under the supervision of the pharmacist. Technicians receive additional training to undertake this role.
- GP-based community pharmacists follow-up patients with high-risk medication plans in liaison with hospital pharmacists.
- The use of one-stop dispensing with patient packs or patient's own drugs labelled for discharge means that most medicines are ready on the ward at the point of discharge.
- Discharging patients with at least 14 days prescription means that there is no rush for a repeat prescription and the GP has time to catch up with the new regime.
- The GP practice has clear protocols in place to update computer records when informed of revised medication plan.
- Electronic prescriptions can assist communication between the ward, pharmacy and GP practice. Electronic signatures have been used within an agreed clinical governance framework. The patient's prescription is electronically transferred to the patient's GP via NHSnet.
- The use of a TTA cupboard at ward level has helped the pharmacist dispense simple prescriptions on the ward. The cupboard can only be accessed by the pharmacist and contains ready-labeled prepacks of routinely prescribed antibiotics, analgesics and

topical preparations. The pharmacist visits the ward during or immediately after the ward round and screens and dispenses any discharge prescriptions.

- Patients are fully counselled on how to take their medicines either via enhanced training for nurses, counseling by pharmacists or fully trained pharmacy technicians. They are given an instruction sheet showing when to take their medicines prepared by pharmacists or pharmacy technicians.
- Pharmacists are writing discharge prescriptions instead of junior doctors in collaboration with the multidisciplinary team and consultant with medical responsibility. The medical practitioner is still currently responsible for signing the prescription where medication changes have been made, however this may change.
- Pharmacists are writing discharge letters on medicines giving full medication profiles and details of changes made to medication during the patient's hospital stay.

A5.1.8 References

1. Cunningham [initial needed] *et al.* (1997). Drug related problems in elderly patients admitted to Tayside hospitals, methods for prevention and subsequent reassessment. *Age and Ageing* **26**: 375–382.

2. Manesse, C. *et al.* (1997). Adverse drug reactions in elderly patients as contributing factor for hospital admissions: cross sectional study. *British Medical Journal* **315**: 1057–1058.

3. Green, P. and Rees, L. (1999). Hospital discharge of elderly patients: is seamless care achieved? [Abstract]. British Pharmaceutical Conference, Cardiff. *Pharmaceutical Journal*, **263**.

4. Jones, S. (2002). Assessing the effectiveness of one stop dispensing. *Hospital Pharmacist* **9:** 237–239.

5. North, S., Leach, D. and Goodson, S. (2000). Clinical technicians could deliver seamless care. [Abstrct, conference], *Pharmaceutical Journal* **265**: 527–528.

6. Hospital Pharmacists Group (2002). One-stop dispensing. Use of patients' own drugs and self-medication schemes. *Hospital Pharmacist* **9**: 81–86.

Appendix 5.2
Discharge checklist

Checklist to be completed 48 hours before discharge.

Task	Completed by and comments	Date/signature
Written and verbal advice given to patient		
Patient care discussed with family/carer.		
Arrangements confirmed		
Family/carer advised of discharge date		
Carer understands how to use any specialist equipment provided		
Transfer of care co-ordinator responsibilities confirmed & note of new coordinator made		
Discharge letter completed and signed		
GP letter written		
Letter faxed or e-mailed to primary care		
Transport arranged: Own Hospital		
Arrangements for home equipment confirmed		
Training in use of equipment completed		
Relatives asked to bring outdoor clothes for patient to go home in		

Checklist to be completed on day of discharge with patient.

Task	Completed by & comments	Date/signature
House Keys Heating on Food available		
Medication instructions discussed with patient and/or carer		
Prescription arranged		
Prescription dispensed		
Community therapies informed		
Community nursing informed		
Out-patient appointment given		
Transport confirmed		

Appendix 5.3
Equipment provision

5.3.1 Why this matters

Many people require equipment or adaptations to help them manage at home, or for their carers to be able to care for them safely. There will be other occasions when equipment or adaptations are required in a care home, residential home or a sheltered housing environment. Delays in completing assessments and in arranging any necessary equipment have caused considerable problems in many parts of the country for a number of years. These difficulties have contributed to delays in discharging people from hospital. The government has stated that by December 2004 all community equipment for older people (e.g. aids and minor adaptations) will be provided within seven days of it being requested. Subject to legislation, from April 2003, the government plans to remove charges for community equipment, such as handrails and hoists.

Traditionally responsibility for providing equipment has been split between the NHS and local authority social service departments. By 2004, all areas are to have a joint provision in place with agreed assessment and access criteria. This is intended to reduce waits for people and should help facilitate the promotion of independence and the appropriate discharge arrangements for individuals. This should also help services ensure that appropriate staff are involved in home visits. Training programmes will need to be put in place to ensure that staff expertise supports the new local arrangements for the prescribing of equipment introduced as part of the joint provision initiative.

Generally the equipment or adaptations that are required fall into four categories:

- Simple and easily transportable equipment which can often be purchased from commercial outlets and for which only minimal instructions for use is normally required, e.g. walking stick, bath seats.
- Equipment where the patient or their carer requires training in the correct use of equipment. This will address the repair and maintenance of the equipment. Often this equipment needs delivering to the patient's home and will require installation, e.g. hoists, beds, grab rails.
- Adaptations to the home, often where the skills of an architect are needed following assessment by a therapist and where a grant may be needed to fund the work. Arrangements for Disabled Facilities Grants and the funding of such work vary across the country and with the ownership of the property. Delays in referral and in completion of any necessary works can result in a patient's discharge being delayed or interim accommodation having to be found until the work is completed.
- Wheelchairs (manual and electric).

Care homes providing nursing care are expected to have, as part of the facilities they provide, some standard items of equipment for anyone needing them and for the safety of staff. These should include hoists, wheelchairs for occasional use, bath and shower seats and fixed items such as grab rails. All other items of equipment to meet the needs of an individual should be, or should have been, provided to them on the same basis as if they were living in a private house, applying the same eligibility criteria.

The timing of the delivery of equipment to a patient's home is important if a safe and needs-led discharge is to take place. Hospitals need to understand that the local ambulance service is generally not able, or equipped, to take home equipment other than walking frames. Timely delivery can be facilitated by:

- having a hospital store for simple equipment that can leave the hospital with the patient;
- the use of staff, such as technical instructors, in a hospital-based occupational therapy department or a member of social services, to deliver equipment at the point of discharge or in advance when possible.

Local initiatives that can support the effective provision of equipment include:

- Local areas funding, and regularly providing, through their wheelchair service, accredited therapist training programmes for assessment for wheelchairs for mainstream therapists who can then access the system on an agreed basis.
- Local reviews of the take-up of the wheelchair voucher scheme to give patients greater choice in the chair they will have.
- 'Handyman' schemes that ensure equipment and minor adaptations are installed in a person's home within a few days of referral.
- Temporary accommodation for people waiting for complex adaptations to their home so they can be discharged from the acute sector prior to their move home.
- Assessment centres that enable people to try out alternative or a range of pieces of equipment prior to reaching a decision on what is most appropriate for them.
- The provision of clear information for those people who require equipment, and their carers, on how it can be returned when no longer required.

More information can be found on the ICES website www.icesdoh.org and in the Care and Repair England publication *On the mend – hospital discharge and the role of Home Improvement Agencies.*

Appendix 5.4
Discharge lounges

A5.4.1 What are these?

Discharge lounges have been established in many acute hospitals. These are comfortable, staffed areas where patients can wait for transport home once they no longer require the level of nursing care offered on an in-patient ward. Patients can be collected from these areas by family members or transport services to take them home. Meals, drinks and basic nursing care are all available. Ideally, they are located in an area of the hospital where there is easy transport access for ambulances. Some provide beds for patients to wait in but the majority provide 'chairs only'. An agreed level of involvement with the pharmacy service is key to their success so patients can receive their take home medication and receive final advice/information on it in this area.

The advantages of discharge lounges are:

- Pressure on wards is decreased and capacity increased.
- Transport services do not waste time looking for patients who have been moved from the ward that booked their transport to another.
- Patients waiting for relatives, friends or transport services to take them home are not occupying a hospital bed.
- Delays in waiting for discharge medication can be avoided.

Factors required for success:

- An operational policy that is reviewed and updated regularly.
- A clear understanding within the hospital of the purpose and use of the area, e.g. ward staff know what has to be in place before a patient is moved to the lounge.
- Clear communication with patients and carers regarding the area, e.g. through leaflets.
- Regular input from the pharmacy service, often from a pharmacy technician.

Appendix 5.5

Discharge needs of people who are homeless

A5.5.1 What are the current problems and issues?

In England most providers of services to homeless people can point to examples of poor practice in terms of unplanned discharges from hospitals (particularly from acute sector wards). Where this happens structured discharge planning arrangements may be in place, but not properly implemented. Far more significant is evidence that follow-on or resettlement arrangements have broken down, or that people are discharged inappropriately back to hostels after a hospital admission.[1]

Homeless people generally have more acute medical problems than the general population. There are situations where homeless people are hospitalised for short-term treatment and then discharged to inappropriate places or back into homelessness. This can be due to a lack of information regarding the living conditions of homeless people, which may result in hospital staff discharging them without making contact with relevant service providers. In addition, poor planning may result in someone losing a hostel bed space. It is vital all hospitals consider the housing situation of patients to ensure that people are not discharged to inappropriate places, homeless or become homeless as a result of their stay in hospital.

The hospitalisation of a homeless person may present an opportunity to deal with underlying medical, social and mental health problems in a structured manner. However, certain procedures, particularly with regard to the discharge of patients, need to be addressed in order to reduce the risk of homelessness. Sometimes, workers report that there has been an inadequate risk assessment under the care programme approach and information has not been passed on to either primary care staff or service providers.

It is vital that there is good liaison between hospital and service providers particularly around homeless women with children. Surgery is not straightforward for a mother with children who may be living in temporary accommodation with no family or friends. Children may have to go into temporary foster care. The initial stay in hospital may need to be extended. There is evidence that community midwives may not be able to provide postnatal care and support to women living in temporary accommodation.

All acute hospitals should have formal admission and discharge policies which will ensure that homeless people are identified on admission and their pending discharge notified to relevant primary health care services and to homeless services providers. In addition, for patients in psychiatric hospitals/units a post-discharge care plan will be drawn up well in advance of discharge and procedures put in place to ensure appropriate accommodation and continuity of care is in place for each person discharged.

A5.5.2 Action plan

The lead managers for hospital discharge in acute hospitals and social services should ensure that their hospital discharge policy includes guidance for staff dealing with individuals who are homeless and aged both under and over 65 years.

It is usually the role of social services to facilitate the care of people over 65 years in liaison with the local homeless unit. The needs of those under 65 years are covered by the local homeless unit.

Good practice can be achieved when there is a clear agreement between the homeless unit, the acute hospital and the primary care trust on how appropriate and timely referral and liaison between the three units can be established. This is essential in order to: support the discharge of individuals who are homeless; ensure they have access to primary care services who will oversee their clinical care following discharge; and ensure acute facilities are not used inappropriately.

A5.5.3 References

1. Fisher, K. and Collins, C. (1993). *Homelessness, health care and welfare provision.* London: Routledge.

Appendix 5.6 Admission of people with additional needs – learning disability, mental health problems or dementia

A5.6.1 What are the issues?

Most people admitted to hospital will experience some level of psychological distress that professionals will need to address. However, people who present at A&E departments or require treatment in an acute hospital setting have difficulties beyond that of their physical health needs and may need some specialist input. This can be the result of, for example, mental health problems, substance misuse, a confused state, dementia or a learning disability. This may present additional challenges for both the individual and for staff in the acute sector. In particular they may find it difficult to identify and then meet needs. The challenges for staff not familiar with working with people with such difficulties can be compounded when patients feel frightened, confused and bewildered, unsupported and unable to communicate effectively. These can continue after someone is admitted. While they can be lessened by involvement of members of specialist learning disability, substance misuse and mental health teams, many acute services are slow to engage the support of these experts or carers, who can be an invaluable resource and support to staff and to patients.

Common problems for these individuals include:

- staff having communication challenges that make it difficult to assess whether the patient is able to provide consent and/or understand the processes he or she is to undergo;
- open ward environments not providing a feeling of security that many people need, as the ward environment is busy and confusing;
- the emphasis on rapid discharge limiting the time for thorough assessment and people's full needs are not always identified or treated. They may return to the community, or institutional care, with needs still not met;
- care plans being made without vital information being obtained from those health, social care, family carers or housing services that are aware of their needs and current difficulties.

Some common difficulties for acute hospital services include:

- links between specialist services and A&E, e.g. liaison mental health or learning disability services not being in place, or are not used effectively. Staff from these services can provide vital information on the individual's health and social needs, and also help them understand what the A&E process involves. It may be that a gateway worker will be available through A&E departments to respond to people with mental health needs who need immediate help. These staff will be able to call on crisis resolution teams if necessary;

- delays in getting expert input for more detailed assessment or rehabilitation as this is not agreed/funded, or acute staff do not consider this early enough in the assessment process;
- the demands on carers, and the importance of a thorough assessment of their own needs when the patient has severe and/or enduring mental health problems or dementia not always being appreciated. This can lead to delays in requesting carers assessments and/or incomplete and unrealistic discharge planning;
- other in-patients may feel uncomfortable when someone with these additional needs is in a bed close to them. This may be especially so if the person is behaving in an agitated manner, or displaying challenging symptoms or behaviour. This can cause anxiety in both patients and staff, and lead to the feeling that their individual needs may not be met as well as they might be;
- the hospital environment, or occupational therapy department, not necessarily being the best place to assess practical abilities. It can be the case that activity of daily living assessments done in hospital are not effective or do not give a true picture of what the individual's abilities will be in their familiar home environment;
- acute multidisciplinary teams often being slow to access specialist mental health team advice. This means that assessments are not holistic and can take too much account of physical health needs, and not mental health ones. It often means that expert input is not sought until there is a crisis;
- different rehabilitation needs not being understood, nor the approaches that may help facilitate a successful discharge;
- the limited number of quality services for people with dementia to move on to, can make it hard to discharge someone when there is no longer a need for the acute sector to be involved in their care.

A5.6.2 Actions for commissioners

Commissioners may wish to consider:

- the need for mental health and learning disability service input to A&E;
- supporting the on-going role of advocacy services and their input to the acute sector and for services commissioned for mental health and learning disability to be able to work with a patient while they are involved with the acute sector. Alternatively ensure the Patient and Advisory Liaison Service has appropriate links with specialist services for advice and support;
- supporting the development of non-verbal communication systems, e.g. picture books;
- commissioning space on older people's mental health wards for those admitted with acute confusion by providing a more suitable environment.

A5.6.3 Actions for acute, mental health and learning disability service

Managers may wish to consider:

- supporting the provision of training for acute staff in issues of consent, basic mental health, dealing with people who are confused and the impact of having a learning disability on physical functioning and communication;
- developing protocols or guidelines for dealing with both emergency and planned admissions and presentations at A&E, including simple pictorial means of communication for people with a learning disability (see Appendix 5. 7 for an example);
- providing active support and time for practitioners from learning disability and mental health teams to support individuals when in acute and physical health care sector;
- working with the police to consider locating a 'place of safety', as defined in the Mental Heath Act, adjacent to A&E;
- support training and support for Patient Advisory and Liaison Service workers.

Practitioners may wish to consider:

- actively engaging the CPA (care programme approach) co-ordinator for and with the client in any pre-admission work that takes place with the acute sector, e.g. attend appointments, visit the ward, speak to the staff;
- if working in the acute sector, looking at each patient as an individual and understanding the anxieties he or she may have and working with staff in specialist services to alleviate these;
- actively seeking the involvement of families and/or professional health or social care staff.

A5.6.4 Good practice examples

- Intensive home support from the community mental health team or community team for people with a learning disability to ensure that admission is short as possible.
- Regular visits to acute wards/community and rehabilitative schemes to support individuals and staff in working with the client.

Appendix 5.7 Guidelines for the acute sector when caring for someone with a learning disability

A5.7.1 Preparation for admission

A5.7.1.1 Making contact

It is advisable for the hospital ward/unit to make contact with the individual as far in advance as possible so that arrangements can be made. These may include:

- pre-admission visits for the person with a learning disability (patient) and carer;
- discussing issues of consent;
- arranging longer appointments;
- making links with the community team for people with a learning disability /social work team.

However, by 2005, every person with a learning disability who wants one will have a health action plan (HAP). A HAP is a personal plan detailing the actions needed to maintain and improve the health of an individual and any help needed to achieve this. The plan will usually be co-produced with them. A HAP may cover day-to-day issues such as diet, exercise, medicines, going to the dentist and to the optician. It can also include more temporary plans to cover specific episodes such as going into hospital for an operation. If the person does not already have a HAP this would be a good time to start one. Good practice guidance on HAPs is at website: www.doh.gov.uk/learningdisabilities.

If appropriate, this contact may also include the individual's parent, family carer or a residential carer.

A5.7.1.2 Reducing anxiety

It is well recognised that some people with learning disabilities are anxious about receiving medical treatment. For this reason, preparation is essential to eliminate any fears and minimise concern and may require several visits to the ward/unit for relationship building and developing an awareness of what to expect with medical procedures.

This contact aims to help the ward/unit team to understand any special needs of the individual.

A5.7.1.3 Involving the community team for people with learning disabilities

If the person lives independently the local community team for learning disabilities could be approached to offer support to the individual if requested. Prior to admission the community team for learning disabilities could also provide liaison with and links between the:

- GP and the primary health care team;
- social work team;
- relevant hospital ward/unit.

This support could also be extended to support the individual with hospital discharge arrangements.

A5.7.1.4 Contacting the community team for people with learning disabilities

The individual's named/assessing nurse is advised to contact the community team for learning disabilities before admission for advice and support as needed.

The intensive response nurse or the healthcare co-ordinator will then make links with colleagues from the community team and/or social work team as appropriate.

A5.7.2 The hospital book

A5.7.2.1 Before using the hospital book

For people with learning disabilities, the personal information book will provide personal care information that will enhance their stay in hospital. A person with learning disabilities, parent, carers or the nurse completing the book can obtain good health and social history through its use.

A5.7.2.2 Accessing the completed book during admission

It is recommended that a copy of this book is kept by the person with a learning disability (patient) or if the patient has given consent, it may be kept with the patient's records for easy access by the multidisciplinary team. This can promote the patient's care in hospital whilst enabling communication of needs.

A5.7.3 Emergency admission

A5.7.3.1 Prior to arrival

If the person with a learning disability needs an emergency admission to hospital, and if the individual has special needs, the carers should be encouraged to contact the A&E department prior to arrival and inform them of the special circumstances.

A5.7.3.2 At triage

The triage nurse should be informed of patient's expected arrival.

A5.7.3.3 Support for parents/carers

In some situations the triage nurse/medical staff/health professionals need to be responsive to parents'/carers' needs as they may be upset and worried and need additional support.

A5.7.3.4 Contacting parent/family/next of kin or carer

If the patient presents to the A&E department on their own, the appropriateness of making contact with their parent, family, next of kin or carer should be raised. This contact may help the A&E team to understand any additional support needs of the individual so that provisions can be made.

A5.7.3.5 Using the hospital book

The hospital book will provide additional information on communication and personal needs. The triage nurse should refer to the patient's hospital book and use supportive material to perform an assessment that involves the patient.

A5.7.3.6 Waiting areas

Access to quiet waiting areas should be made available to minimise additional concerns the individual may be experiencing during this time.

A5.7.3.7 Fast tracking through Accident and Emergency

The A&E nurse and the doctor responsible for the patient's carers will 'fast track' the patient through the department when this is deemed to be necessary.

A5.7.3.8 Preparation for admission to a ward

If the patient is due to be transferred to an in-patient's unit/ward in the hospital, where appropriate, the A&E nurse should advise this department to contact the:

- person's parent/carer;
- learning disabilities resource nurse for the ward;
- healthcare co-ordinator/duty intensive response nurse at the community team for learning disabilities;
- health facilitator for advice about local arrangements for specialist learning disabilities support (every primary care trust should have an identified health facilitator and there should be a named contact for health facilitation for each GP practice).

A5.7.4 Admission to the ward

A5.7.4.1 The admission process

During admission it is good practice to obtain the handover from the carers, with full involvement encouraged from the patient. Details of the main carer and contact numbers should be clearly documented in the patient's nursing notes.

A5.7.4.2 The handover

The handover to the ward nurse should involve the patient, with the use of the personal information book and the attached picture sheets.

A5.7.4.3 On going patient involvement/information

During their stay in hospital the patient and, if appropriate, their carer should be kept informed of their multidisciplinary care plan.

A5.7.4.4 Carer support

The ward/unit nurse should discuss with the patient and the carer the support that the carer/parent may be able to provide. This may be short term (e.g. to help the patient settle in the new environment) or long term (e.g. regular visits around meal times).

If this is not possible and the carers are unable to accompany the patient at regular intervals, a detailed support plan, including dietary and communication needs and the personal information book should be made available from the carer through a handover to ward nurse.

A5.7.4.5 Communication

The patient will require extra time for care and communication, especially during the early days following admission. The hospital book will help people with learning disabilities communicate their needs in hospital. It will also enable hospital staff to help the person to make decisions about treatment and investigations.

A5.7.4.6 Recovering

During recovery, health professionals need to take into account that a person with a learning disability may require longer time and additional encouragement to make a full recovery. It is important to gain the co-operation of the patient at their own pace. The hospital book will prove useful here.

A5.7.4.7 On going support during the hospital stay

Additional time and support needs to be allocated when an individual is recovering from surgery. Carers should be encouraged to participate in helping the individual with their treatment when requests are made by nurses, physiotherapist, doctors and occupational therapists to participate in exercises to aid with rehabilitation.

When explaining treatment, it is advisable to obtain support from the patient's carer, their community learning disability nurse, social worker and/or other relevant specialists from the learning disability team, such as speech and language therapists, physiotherapists, psychologists and psychiatrists. Documentation of the action plan needs to be completed by all involved.

Along with the use of the hospital book and the attached picture sheets, hospital staff should be encouraged to use additional appropriate communication resources to assist communication with a person with a learning disability. These pictorial resources can be used to help the person understand their treatment and investigations, as well as communicate their personal and clinical needs.

Prior to discharge the ward/unit nurse should liaise with the health or social care professional supporting the individual. In the first instance liaison should be with the intensive response nurse/healthcare co-ordinator at the community team for learning disabilities and/or the learning disabilities duty social worker. If appropriate, it is advisable that the home care team and primary health care teams should co-ordinate the discharge arrangements.

Appendix 5.8

Common problems and simple solutions

A number of issues contribute to the delays in the timely transfer of a patient from one care setting to another or to his or her own home. There is a remarkable consistency in the issues that cause delays. In many instances very simple and relatively cheap solutions can reduce the impact of these. *Diagnostic work should be undertaken to analyse the problem and to engage the key stakeholders in determining the right solutions.* The list below provides some practical ideas to facilitate discussion.

Co-ordination of patient journey

Problems	**Solutions**
Discharge is concentrated between Monday and Thursday	➜ Services are commissioned and organised over 7 days a week ➜ Actual discharge day is agreed with family and carers to take account of support they can offer
Limited services to help prevent avoidable hospital admissions, provide health promotion or chronic disease management schemes	➜ Falls clinics ➜ GP clinics based in A&E ➜ therapists based in A&E ➜ falls co-ordinator links with local exercise groups for older people and provides support and/or training
Primary care service unclear if admission of patient necessary to meet clinical needs	➜ Agreed 'hot line' arrangements for GPs for immediate responses in relation to health and/or social care ➜ Consultant liaison to GP practices for additional advice
A&E only point of access for out of hours intervention	➜ GP out of hour co-operatives based in, or near, A&E ➜ Wide publication of NHS Direct phone number ➜ Community nursing out of hours and social services department out-of-hours duty services work together to access information and support people until mainstream services are available, e.g. agreed access to community and primary care information, pooled budget for generic staff
Limited medical cover in the community at night	➜ Base night nursing service with out of hours GP co-operatives to increase staff resources and allow sharing of expertise
Peg feeding once initiated is not reviewed and may lead to readmission or patient having to rely on peg for longer than necessary	➜ Service exists for SALT and/or dietitians to follow up and review the appropriateness of on-going peg feeding

Co-ordination of patient journey – *continued*

Problems	Solutions
Delays in discharge occur due to disagreements over the funding of giving sets for peg feeds	➜ Management of budget for 'peg feeding' held by the one services to cover in- and out- patient work and care home care ➜ In-patient/hospital based dietitic department moves patient on to the products provided in their local area a few days prior to discharge when patient is from another area
Limited, if any, follow up for people with dysphagia	➜ Provide speech and language therapy input as part of intermediate care services

Communication between primary and secondary services and continuity of approach

Problems	Solutions
Primary or social care believe they do not get the information they require on a patient when transferred from the acute sector	➜ Involve primary and secondary care staff in agreeing standard admission and discharge documentation, e.g. a form to be sent at time of admission and discharge
Delays in information getting to primary care from bed-based services	➜ Fax machine on each acute ward with report sent as patient leaves the ward and readily accessible in other settings
Delays in obtaining equipment necessary to support discharge	➜ Hospital-based store for simple and frequently required equipment and therapy staff able to issue and deliver ➜ Protocols for access to joint equipment store
Patients resume home medication on discharge from hospital and do not understand, or comply, with the new medication regime	➜ On admission medication reviews are undertaken by a pharmacist, a medication care plan put in place, and compliance training undertaken
Delay in discharge when training for carers required re manual handling and other aspects of caring for someone with physical and/or communication difficulties	➜ Agreement between primary care trust, social services and acute trusts re responsibility and funding ➜ Training programme for families and carers provided on regular basis, possibly by, or in conjunction with, voluntary sector

Internal acute hospital issues

Problems	Solutions
Information on home circumstances very slow in getting to hospital	➜ Local schemes that allow ambulance service to bring essential information on, e.g. message in a bottle ➜ Primary care identify at risk patients who then carry a small card issued at the GP surgery that contains key medical and social information
Information about the patient is not available in the one place in the hospital	➜ One set of notes used by all and held at ward level

Internal acute hospital issues – *continued*

Problems	Solutions
Outliers on wards in an acute hospital miss consultant round leading to delays in all aspects of care	➜ Case co-ordinator system operates in hospital ➜ Protocols to allow nurse or therapist discharge ➜ Hospital-wide system for identification of outliers to prompt care co-ordinator to ensure that discharge plan is in place and followed ➜ Care co-ordinator advises hospital discharge team daily of any new oultiers ➜ Hospital discharge team visit all outlier wards daily
Delay in obtaining therapy input	➜ Agreed criteria for referral to therapy services ➜ Named therapist per ward/beds ➜ Proactive use of therapy support workers to screen patients for rehabilitation potential ➜ Development of generic worker role to work across nursing and therapy
Inappropriate timing of referrals to social care	➜ Agreed criteria for referral to social work services ➜ Named social worker/care manager per ward/beds or central referral number ➜ Proactive use of social care support workers to screen
Hospital team is slow to identify complex issues that will cause delays in discharging, e.g. no GP, major housing adaptations, homeless	➜ Develop a simple risk screening proforma to be used on admission ➜ Care co-ordinator to organise comprehensive assessment and involve multidisciplinary team as required ➜ Advise discharge team of such patients to enlist their help early in the process ➜ Introduce a file system that makes it easy to identify them, e.g. patient record in a particular coloured folder, special front sheet in notes
Patients with challenging behaviour and/or cognitive in-patient are not well served in acute wards and can cause a risk to others	➜ Agreements are in place for rapid access to specialist mental health and learning disabilities opinion from medics or nurse specialists enabling a shared care approach
Uncertainty in A&E about the most effective way to work with people who may have, or do have, mental health problems, confused state and/or a learning disability	➜ Mental health & learning disability services to have clear out-of-hours liaison services and links with emergency services ➜ Simple training programme for A&E staff provided by specialist teams
Patient with mental health problems. Learning disability and/or dementia present management problems on the acute ward	➜ For planned admissions, the care programme approach key worker attends hospital with patient in advance of admission to allow them to see environment and to discuss management issues with acute ward staff/team ➜ Liaison services provide immediate input within agreed referral protocols available or patient not known to the local specialist mental health or learning disability team

Communication with patients and carers

Problems	Solutions
Patient and/or carer feel unsupported immediately after discharge and uncertain about arrangements put in place and/or how to use equipment	➜ Practice nurse, health visitor for the elderly, healthcare assistant or member of the ward team phone on day after discharge to check how patient/carer is managing ➜ 'Home from hospital' schemes for people living alone ➜ Patient leaves hospital with phone number to contact for advice/reassurance
At point of discharge carers state they are not able to, do not wish to have their relative return home	➜ Clarify at the outset of the care episode the involvement patients want their carer(s) to have in the decision making process re their care ➜ Provide training for hospital-based staff on the principles of working with carers as partners ➜ Agree who in multidisciplinary team has lead role in liaising with carers on an individual patient basis ➜ Have information for carers on their rights to an assessment available

Individual patient characteristics

Problems	Solutions
Patient or carer not able to understand written information available	➜ Patient and information available in local languages, on tape, in pictorial form, in simple booklets ➜ Use of advocates ➜ Care co-ordinator checks understanding and reinforces messages in visual forms where necessary
Patient unable to understand, and easily participate, in decision making process re their care due to communication difficulties	➜ Ensure that the speech and language therapy service is involved in agreeing the nature, content and style of leaflets and that patients with communication difficulites, e.g. aphasia, are seen by a therapist ➜ Speech and language therapy service provides training for other practitioners in working with people with communication difficulties
Patient does not speak English	➜ Contract with interpreting services to avoid inappropriate use of family members, especially of children
Patient does not have a GP	➜ Primary care trust allocates GP as soon as possible after admission ➜ Primary care trust has named person for acute sector to contact on these occasions

Staffing issues

Problems	Solutions
High need for use of agency staff who do not understand the English health and social care system	➜ Display pathway pictorially and as simply as possible ➜ Use check lists as an aide memoir
Junior doctors unfamiliar with local services and policies re: admission and discharge	➜ Limit the number of wards that a junior doctor has to cover ➜ Formal induction to cover discharge planning, prevention of admission schemes, community resources
Staff lack understanding of wider system	➜ Shared agency induction programmes ➜ GP practices host forums with other practices and social services department to share ideas and good practice ➜ Rolling programme and open inivtation to the independent and acute sector to learn with primary and social care staff ➜ Shadowing programmes for key personnel

6. Intermediate care, transitional care and sheltered housing

The *key principle* underpinning this aspect of an effective discharge and transfer of care policy is that:

- Transitional and intermediate care services are used as effectively as possible, so that existing acute hospital capacity is used appropriately and patients achieve optimal outcomes.

There are now a number of services and new ways of working that provide person-centred care and enable people to live in a supported environment with appropriate care, support and, at times, rehabilitation. These services can also support the acute sector in preventing avoidable admissions, facilitating timely discharge and in providing capacity within a local health, housing and social care system.[1]

6.1 Intermediate care

The *NHS plan* set out a new programme to promote independence for older people, by developing a range of services delivered in partnership between primary and secondary health care, local government services, in particular social care, and the independent sector. Intermediate care is a vital component of that programme and is central to the modernisation agenda. Intermediate care is a range of integrated services that are intended to:

- promote faster recovery from illness;
- prevent unnecessary admission to an acute hospital bed;
- support timely discharge;
- reduce avoidable use of long-term care;
- maximise independent living.

This support can be delivered into an individual's own home, housing schemes, day centres and hospitals, as well as in more traditional care and rehabilitation settings such as community hospitals and care homes. However, it needs to be accepted that these services are not only provided as part of *intermediate care* initiatives – other services can also provide facilities that fulfill these purposes.

Intermediate care is not an optional extra. It is designed to ensure that patients get the right kind and quality of care at the right time. It contributes to the effective use of resources and capacity in the health and social care system at a local level.

Partnership is at the heart of intermediate care. To be effective, services and new ways of working need:

- the active co-operation of organisations, and of professionals;
- to be person-centred;
- to promote the independence of people actively and consistently;
- to support carers in promoting the independence of their relatives and to help them understand the role they can play, and the means they can use, in doing this;
- to be based on whole system working;
- to be able to provide timely access to specialist care;
- to support the promotion of health and an active life for older people.

In order to ensure a consistent approach to intermediate care the Department of Health advised the NHS and local authorities of the definition that they were to apply in reporting investment and activity.[2] These can be summarised as services that:

- are targeted at people who would otherwise face a prolonged and unnecessary stay in hospital or an inappropriate admission to acute in-patient care, long-term residential care or continuing NHS in-patient care;
- are provided following a comprehensive assessment that results in a care plan that has active therapy, treatment and/or time for recovery as part of it;
- have a planned outcome of maximising independence and wherever possible allowing individuals to live at home;
- involve cross-professional working, with a single assessment framework, single records and shared protocols.

6.1.1 Success factors

The experiences of the change agent team and the work of the Audit Commission[3] and King's Fund suggest that there are a number of practices that actively support the successful implementation and delivery of intermediate care.

These are:

- there is a single point of access that is widely known in a local area;
- services are person-centred and tailored to meet individual need;
- services are responsive, flexible and can be adapted to suit the needs of an individual;
- services are provided in a range of settings – an individual's own home, bed-based and day services;

- an active case-finding approach is adopted to identify as early as possible the rehabilitation potential of an individual or for intermediate care staff to go into the hospital to identify those who would be most likely benefit from their services;
- staff providing services are empowered, clear about their accountability and are highly skilled, adopting a rehabilitative approach;
- there is co-ordination at a strategic and an operational level;
- services are well promoted locally and their place in the system understood;
- the single assessment process links all care sectors – housing, health and social care;
- there are strong and respected leaders at all levels in each organisation and robust leadership of the whole system approach;
- performance review is a regular feature of the service and all partners are willing to respond quickly to improve service delivery where deficiencies are found;
- the accountability and responsibilities of the different organisations providing services are agreed.

Further detailed information on intermediate care is available on the website – www.doh.gov.uk/intermediatecare and the Change Agent Team website www.doh.gov.uk/jointunit/changeagents.htm/. The King's Fund publication *Developing intermediate care – a guide for health and social care professionals*[1] offers a comprehensive overview of intermediate care and practical advice and information.

6.2 Transitional care

Transitional care refers to that care provided to a person who is not able to be placed in their home or the permanent setting of their choice but who still requires a supportive, and appropriately staffed, environment to live in. It can be used, for example, while someone is awaiting major adaptations to their own home. The essential feature is that the individual is there on a temporary basis, and there is an agreement that this is the case with the person, their carers, if relevant, and those administering the placement. All should be clear as to why the placement is needed and for how long. The care provided must be appropriate to the person's needs, including providing rehabilitation, support, confidence building and time for recovery.

These placements can be provided by the NHS and the independent sector. Community hospitals can be used for this purpose, but only when agreement has been reached regarding a long-term placement.

6.3 Sheltered housing

This is specially designed accommodation, available for rent or purchase, mainly for older people. It is sometimes called retirement housing. Some sheltered schemes are called 'extra care sheltered housing' or 'very sheltered housing'. In recent years the nature of sheltered housing has changed and many housing schemes provide intensive support to residents. Both sheltered and extra care housing can be available locally. Their use for an individual should be based on an assessment of their needs and a decision that the support and care offered is appropriate to those needs. This can be extended to supporting and keeping people in their own home, but managing their care in the sheltered housing at times of sickness/crisis, which can also be used as a setting for intermediate care in short-term residencies.

Sheltered housing can offer a range of services to support older people to live independently. Alarm services, scheme managers, a sense of community and good design all contribute to the ability of sheltered housing to support individuals. Scheme managers can play a key role in supporting the discharge of an individual and in ensuring that there are support mechanisms in place to meet their needs.

Very sheltered housing provides a greater amount of support. It may use care staff and routinely provide meals for residents. Wardens in these schemes can play a key role in supporting someone in the community. Further information is set out in Appendix 6.1.

More information on very sheltered housing, including leaflets for NHS staff, social services, sheltered housing providers and for older people, their friends and relatives can be obtained from EroSH (The National Consortium for Sheltered Housing) on 01905 21112.

6.4 Action plan

Primary care trust commissioners with their local acute providers and their social service colleagues should consider:

- agree referral protocols for the use of, and access to intermediate care and transitional care;
- consider the need for, provision of, and support for sheltered housing provided locally as part of whole-system commissioning;
- develop a single point of access for intermediate care for all referrers;
- agree a means of monitoring the use of transitional care.

Primary care trust commissioners and their social service colleagues should consider:

- assess the local population's need for intermediate care in a variety of settings;
- review existing intermediate care opportunities and, if necessary, take steps to increase capacity to meet local needs;
- engage with housing providers to identify current capacity for intermediate and transitional care beds and the need for a local range of sheltered housing options.

6.5 References

1. King's Fund (2002). *Developing intermediate care: a guide for health and social services professionals.* London: King's Fund.

2. Department of Health (2001). *Intermediate care* (HSC2001/1: LAC(2001)1). London: Department of Health.

3. Audit Commission (2002). *Integrated services for older people.* London: The Stationery Office.

Appendix 6.1 Housing

A6.1.1 Why this matters

Where an individual lives is extremely important to them and can also have a considerable impact on their health and well being. The significant majority of people who are admitted to hospital come from their own homes and want to return there as soon as possible. Sometimes complex adaptations are needed to their homes to enable this to happen. The options for independent living are increased when local areas have a range of housing stock, some with support for older and/or vulnerable people, and local partners work together to review available capacity, options and solutions.

Within a local area the ownership of, and style of housing, will vary. It will include owner occupied stock, local authority stock, an increasing number of housing association owned stock and privately rented accommodation.

Those commissioning services for older people and those with physical disabilities, and possibly sensory impairment, need to be aware of the range of local providers and the range of provision. Housing providers need to be seen as an integral part of the planning and commissioning teams for services.

Cultural and organisational divides and a limited understanding of housing by the NHS, and to a lesser extent social services, have limited effective joint working. While the 'Supporting People' agenda should help address this, the NHS needs to work at understanding housing issues if this sector is to be able to play its rightful role in the care system. A particular issue for NHS staff involved in the discharge of people from hospital, or the avoidance of unnecessary hospital admission, is the system for access to supported housing and also the local system for the funding, planning and provision of home adaptations.

For minor repairs and adaptations to make discharge home possible, the hospital occupational therapist should involve, at an early stage, a local Home Improvement Agency (HIA) (Care and Repair or 'Staying Put' scheme) or handyperson service. Where the HIA also has a dedicated rapid response service team for hospital discharge, the ward-based care co-ordinator should consider involving it directly in discharge planning at an early stage.

Areas for the NHS and housing providers to address together:

What to address	Some actions to consider
Tackling the cultural divide	• bringing staff from housing into mainstream training opportunities; supporting a common language and care culture • look at opportunities for cross learning; shadowing, secondments, mentoring • look at opportunities for locality based forums and events
Planning	• understand the different planning regimes and make sense of them; rationalise use of local information where possible (see below) • the need to link in with housing and Supporting People in mapping existing services, building capacity and identifying gaps in services • consider best value principles in planning across the system
Commissioning	• whole-system approaches to commissioning means including housing as part of the process, not just bolting it on • looking across all existing local services; including sheltered and extra care provision • engage Supporting People in the commissioning process • explore different contracting solutions (flexible contracting, longer contract periods, different options for performance measuring, offering "freedoms and flexibilities" to good providers)
Use of Health Act flexibilities	• look beyond the traditional use of the Health Act flexibilities in health and social care, to including housing based options of care and support. This might include: – involving housing staff as part of rapid response teams – pooling funds for capacity building, reviewing existing housing stock for older people and commissioning extra care housing – creating fluidity between sheltered/extra care and intermediate care arrangements • working with housing authorities on joint assessments

A6.1.1.1 Practical examples

- Use of sheltered and extra care housing for intermediate care activities.
- Home improvement agency projects to provide home safety checks, falls prevention, rapid response repair and adaptation services to older and/or disabled people.

A6.1.2 Further information

The Office of the Deputy Prime Minister and the Department of Health has produced a guide *Preparing housing strategies*, which provides practical assistance in developing health and housing strategies for older people.

Produced by Care and Repair England, *On the mend: hospital discharge and the role of home improvement agencies*, looks at the range of services broadly referred to as 'Hospital Discharge' or 'Home from Hospital' schemes and examines the policy framework in which these services are expanding and developing. Further details can be obtained from http://www.careandrepair-england.org.uk

Practical examples of the role of sheltered housing and Home Improvement Agenices in hospital discharge practices are included in the Department of Health report *Moving forward*. A copy can be obtained from: http://www.doh.gov.uk/intermediatecare/icmovingforward.pdf

A6.1.3 Practical examples

- Use of existing housing for intermediate care services or for interim housing while an individual waits for adaptations to their own home to be completed.
- Confederation of home improvement schemes to provide repair services to older and/or disabled people.
- Use of housing association maintenance units repair services in privately owned stock.

7. Continuing health and social care

The *key principle* underpinning this aspect of an effective discharge and transfer of care policy is:

- The assessment for, and delivery of, continuing health and social care is organised so that individuals understand the continuum of health and social care services, their rights, and receive advice and information to enable them to make informed decisions about their future care.

7.1 What is continuing care?

Continuing care, frequently referred to as 'long-term care', is the provision of care over an extended period of time as the result of disability, accident or illness, to meet both physical and mental health needs. It can be provided in a range of settings, from an NHS hospital, care home or hospice, to a person's own home.[1]

Continuing care can include both health and social care:

- 'Continuing NHS health care' – a package of care arranged and funded solely by the NHS.
- 'Continuing health and social care' – a package of care that involves services from both the NHS and social care'.

The Royal Commission report on long-term care[2] emphasised the need to transform long-term care services by developing new models of support that focused on maintaining independence, rather than doing things to people. The government's policy on long-term care is to improve the range and type of services that help people recover and gain independence. Changes have been made in the arrangements for adults who enter a care home to ensure there is a reasonable length of time between entering it and any question of their needing to sell the family home. This important interval gives people the time to think about their future, and keeps open the possibility of a return home.

7.2 Who is responsible for providing and funding continuing care?

The NHS and local authorities with responsibilities for social services must work together to meet the needs of people with continuing health and social care needs. Strategic health authorities (StHAs) and local authorities are required to agree joint continuing health and social care eligibility criteria, setting out their respective responsibilities for the provision of the full range of health and social care services, regardless of age.[2] They include equally important responsibilities for palliative health care and respite care. The NHS is responsible for arranging and funding a range of services to meet the needs of people who require continuing physical or mental health care. The range of services which the NHS is expected to arrange and fund to meet the needs of people at home or in a care home includes:

- primary health care;
- assessment involving doctors and nurses;
- rehabilitation and recovery as part of a package of NHS care;
- respite healthcare;
- community health services;
- specialist health care support;
- healthcare equipment;
- palliative care;
- specialist transport services.

Primary care trusts and local authorities are responsible for making sure that local arrangements and procedures are in place to assess need and organise care provision, and make clear that a regular review of care needs will be made. Throughout this process the patient and their family must agree the assessment is an accurate reflection of their needs and sign the assessment to that effect. They must also be fully informed of their rights in relation to any decisions made about continuing care provision.

As previously discussed, carers have an entitlement in their own right. The assessment of the patient's needs and the care plan must take carers' needs into account. This plan will reflect both the ability and willingness of the carer to provide support and their needs as an individual.

From April 2003, NHS-funded nursing care will apply to all residents in care homes providing nursing care. All people in care homes providing nursing care will have their needs for registered nursing care assessed. The NHS is responsible for the costs of this nursing care and they are allocated a banding of needs as high, medium or low. A *practice guide and workbook*[3] was issued by the Department of Health in 2001 to assist nurses who are responsible for determining the level of funding support for individuals. It is recommended that the guide is used in conjunction with this publication.

All staff involved in the referral, assessment and decision-making process for continuing health and social care, should be fully conversant with the local eligibility criteria, the referral and funding processes, and must understand their role and responsibilities in caring for patients and supporting carers.

7.3 Where is continuing care provided?

The independent sector is the main provider of continuing care services. This is through the care home and home care provider market and non-profit-making organisations. Over recent years there has been a notable reduction in the number of care home beds available[4] and home care providers are reporting difficulties in recruitment and retention of staff. A person waiting for a care home bed to become available is one of the main causes of a delayed transfer of care.[5]

Although work is underway to review capacity and develop new models of care, there is an immediate need to find solutions to current problems. The government's investment in developing capacity and partnership in care has been directed towards alleviating these pressures.

Primary care and community health services are responsible for meeting the health needs of people residing in the independent sector. There are many good examples of joint working between independent and community services to improve the quality of life and independence of people in long-term care.

In some areas NHS continuing care beds are provided in community hospitals or through contracts with the independent sector for people who meet the criteria for NHS continuing care.

7.4 What effect does the provision of continuing care have on delayed transfers of care?

The systems for agreeing agency responsibility and the funding of care are known to cause delay in the transfer of patients from one type of care to another, for example:[5]

- a referral for care home placement is made too early. This can be before the assessment has been completed and, therefore, may well be before the person has reached his or her full potential;
- there has not been an assessment of the carer's needs;
- there are disputes over funding responsibility;
- there is a lack of clarity about who will provide specialist nursing equipment;
- there is a limited choice of care homes in the local area;
- there are delays in the care home provider assessing the potential resident;
- care home provider uncertainty about who is responsible for arranging the placement and assessment details;
- dementia and behaviour management needs are overlooked or neglected in care planning;
- continence assessment and management is overlooked during the assessment process;
- there is a lack of understanding about legal responsibility for people unable to represent themselves.

7.5 Assessing the need for continuing health and social care

The assessment for continuing health and social care needs is a joint responsibility between the NHS and local authorities with social services responsibilities. This shared responsibility is reflected in the development of a single assessment for older people.

A new referral for continuing care should only follow a comprehensive assessment of need, in the case of older people, or a joint assessment for all other people, and an evaluation of the appropriateness of other interventions, such as a period of rehabilitation and recuperation.

In cases where a person has already been receiving services the care package may simply need reinstating at the point of discharge from hospital. There should be a local agreement between agencies on the minimum notice required to reinstate a care package from the point of referral. This is usually two working days. The ward-based care co-ordinator is responsible for making the referral and co-ordinating the discharge date.

In the case of new referrals, the comprehensive assessment for older people will identify the nature (complexity, intensity or unpredictability) of health care needs. These are the areas that determine eligibility for continuing health and social care. The multidisciplinary team should consider firstly, whether the need is predominantly a health one, indicating continuing NHS health care.

For all other adults, a joint assessment process will be required. The depth and breath of the assessment should be proportionate to the individual's presenting needs. Professionals should explore the intensity of particular needs, including the physical pain, distress or disruption they cause, and the instability and predictability of problems, both on a day-to-day basis and over longer periods of time. The number of different needs required by individuals, how they interact, and how individuals react to the difficulties facing them are also important. Together, the individual and professional should look at the strengths and abilities that the individual can bring to bear on his or her own needs.[6]

Once a care plan has been developed to meet these needs the local eligibility criteria should be applied and responsibility for specific elements of the transfer/discharge care plan discussed and agreed.

It is the responsibility of the ward-based care co-ordinator to make a referral to the discharge planning team for a joint assessment. It is recommended that a single point of referral is established and that a team leader is appointed with the overall responsibility for an integrated health and social care response to such referrals. See Section 5.

Following the assessment there are a number of possible care pathways. These include:

- support at home with a care package of health and/or social care;
- intermediate care;
- referral for very sheltered housing or other model of housing with care;
- admission to a care home that does not provide nursing care;

- admission to a care home providing nursing care;
- admission to a hospice;
- admission for NHS continuing care.

It is important to ensure that every opportunity to enable patients to recover their independence is taken. All decisions made at this stage should be reviewed and a future review date set and agreed with the patient and their family. Any permanent decision to admit a patient to a care home should not be made until the review has been completed.

If admission to a care home providing nursing care is required, the process for determining the Registered Nurse Contribution to Care should ideally be followed before admission, but within 14 days. The independent sector is a key stakeholder in the implementation of the single assessment process and a continuation/transfer of care is required. The independent sector needs to have confidence in the continuity of assessments undertaken in hospital, so that they do not need to carry out another assessment, which can sometimes lead to delay in people being admitted to a care home.

Continence assessment and care planning are an important factor in managing continuing care as a number of people will suffer from a degree of incontinence. The assessment, treatment and management of incontinence should adhere to the *Guidance on continence.*[7] From April 2003, the provision of continence equipment is a NHS responsibility and all individuals should have a specialist assessment to ensure they receive the right treatment and care.

Responsibility for the provision of specialist equipment must be clearly set out in guidance for community staff and care home providers to ensure organisation of the equipment is clear for all concerned.

Independent advocacy services can play a valuable role when the patient or carer has difficulty in communicating their views or when there may be potential conflict of interest between the patient and carer.

An advocate should be free from any professional involvement with any of the services likely to become involved in the care or aftercare of the patient to ensure impartiality.

7.6 The *Direction on choice* for accommodation

If admission to a care home is agreed as the best option, any patient who is being placed with public support is able to choose a home under the *Direction on choice.* The directions are currently undergoing a review to update them in the light of forthcoming legislation and further information will be available.

Because residential placements can be delayed considerably while people wait for a place in their home of choice to become available, transition or interim placement should be considered when the first choice of home is not available. If the interim placement meets a person's needs, it is acceptable for a person to move from an acute setting to a transitional placement until a permanent/alternative choice becomes available.

In circumstances where waiting for a care home placement is causing an unacceptable delay in care transfer, the following processes should be put in place:

- Patients and carers should be informed about the possibility of an interim placement as soon as possible. It is important that people understand that it is inappropriate for them to remain on an acute ward indefinitely while they are waiting for admission to a care home.
- The interim or transitional placement must be able to meet the assessed care needs of the patient and they must receive active help to move on to the home of their choice when a place is available.
- There must be support (such as an independent advisory service) to patients and their carers in making important decisions. Self-funders should also be offered support in making such choices.
- Practitioners should be signed up to the use of transitional placements with appropriate protocols.
- Trusts should have in place agreed policies and procedures to address situations in which patients and their families refuse to move from an acute bed to another setting.

The guidance stresses that when a person's acute episode of ill health has been treated, it is not appropriate for them to remain on an acute hospital ward. This is providing they are clinically fit and have been assessed as safe to transfer. Remaining in an acute ward has disadvantages for the patient and capacity of the whole system.

The *Direction on choice* states that where an individual expresses a preference for a particular type of accommodation within the UK, the placing local authority has to accommodate this request, provided that:

- the accommodation is suitable in relation to the individual's assessed needs;
- to do so would cost the local authority more than it would usually expect to pay for someone with the individual's assessed needs;
- the accommodation is available;
- the person in charge of the accommodation is willing to provide accommodation subject to the local authority's usual terms and conditions for such accommodation.

7.7 Dealing with disputes

The processes for review and resolution of disputes must be clearly set out in the Eligibility Criteria for continuing Health and Social Care.

A comprehensive range of information should be available as described earlier.

7.8 Action plan

Primary care trusts, in partnership with local authorities with social services responsibilities should consider:

- Ensure that the Eligibility Criteria for Health and Social Care is available to all staff involved in the assessment for continuing care.
- Develop a joint training programme on application of health and social care eligibility criteria.
- Consider how referrals for funding NHS continuing care and care home placements can be considered jointly by the responsible primary care trust and local authority. Options include:
    - the joint appointment of an individual able to make a decision on behalf of both organisations;
    - the development of an integrated hospital discharge team with the team leader empowered to make the decisions (see Section 5);
    - a joint panel with membership from both organisations.
- Consider how to integrate the single assessment process with the independent sector.
- Provide information for patients and their carers on how to access health and social care services, agency responsibilities and patient and carer rights.

Primary care trusts and acute trusts should review their current contracts for PEG (percutaneous endoscopic gastrostomy) feeding equipment and jointly contract for the service for acute, community and care homes and the provision of specialist equipment including nebulisers.

Health care managers and the providers of care homes should:

- Work together to support care home staff in delivering care packages through a variety of approaches. These could include:
    - providing clinical guidance by nurse consultants/specialists going into care homes;
    - seconding nurses to care homes to educate staff in clinical procedures;
    - regular input from therapists on the safe use of equipment, the basic principles and practices of rehabilitation, and the safe handling and moving of residents;
    - providing on site training in continence management, managing confusion, tissue viability;
    - providing regular input from a dietitian on healthy eating and on the management of residents who are being PEG-fed;

  - providing regular support from a community pharmacist to help staff understand the importance of medication compliance, common side effects and safe dispensing practice.

- Develop referral protocols that enable care homes access to rapid response teams, community assessment and rehabilitation teams, 'out-of-hours' community nurses support.

7.9 References

1. Department of Health (2001). *Continuing care: NHS and local councils' responsibilities.* (HSC 2001/015: LAC (2001) 18). London: Department of Health.

2. The Royal Commission on Long Term Care (1999). *With respect to old age – rights and responsibilities.* London: The Stationery Office.

3. Department of Health (2001). *NHS funded nursing care – practice guide and workbook.* London: Department of Health.

4. Department of Health (2001). *Building capacity and partnership in care.* London: Department of Health.

5. House of Commons Health Committee Delayed Dishcarges (2001-02). London: The Stationery Office.

6. Department of Health (2002). *Fair access to care services* (LAC (2002)13). London: Department of Health.

7. Department of Health (2000). *Good practice in continence services.* London: Department of Health.

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Moving from long-stay hospitals

The views of Northern Irish patients and relatives

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Abstract A cohort of 68 persons had been resettled from a long-stay hospital over a 5 year period, with over 90 percent moving to residential and nursing homes. Interviews were conducted with 39 residents and 34 relatives. Residents had more likes and fewer dislikes about their present accommodation than about the hospital. Nearly all were happy to have moved. A minority of families had been unhappy before the move. After the move, all families felt the residence was at least equivalent to the hospital, with most rating it as much better. Families liked the staff, the atmosphere, the buildings, and the individual rooms. They disliked the congregated living models, the failure of people to move on, and the dearth of social networks. Recommendations include increased awareness of new housing and support options, regular reviews of clients' needs and aspirations, and opportunities for access to independent advocacy services.

Keywords advocacy; relatives; resettlements

Introduction

In many Western countries, long-stay hospitals for people with learning disabilities have closed or are closing. Emerson and Hatton (2000) report a 48 percent decrease in the English long-stay hospital population from 1994 to 1997. In the latter year, around 7500 patients were still resident in hospitals, but they constituted only 13 percent of all the people with learning disabilities in some form of residential provision. In the United States, 15 percent of people living in formal, supervised residential services during 1996 were in state institutions – some 60,000 persons in all (Braddock, 1999). Similar data have been reported for Australia (Griffen and Parmenter, 1999).

Hence the era of the long-stay hospital appears to be drawing to a close, but more completely in some regions within these countries rather than in others. In the United States, nine states are no longer operating any large-scale facilities for these clients, whereas 13 states have not closed any large facilities, nor do they propose to do so, although they are reducing them in size (Braddock, 1999). This regional variation is also evident across English health authorities (Bailey and Cooper, 1997) and similar variations are found in the other countries which make up the United Kingdom.

The improvement in people's quality of life on moving from hospital to community settings continues to be documented (Cooper and Picton, 2000; Srivasta and Cooke, 2000) and the findings generally confirm the conclusions of a thorough review commissioned by the English Department of Health in 1994 (Emerson and Hatton, 1996). In the main, the resettlement of patients has produced a better life for them, not least in terms of their physical surroundings but also in the opportunities it provides for the development of communication and domestic skills, increased contact with family and friends, and the use of community facilities. However, some studies have reported some deterioration in people's psychological wellbeing, with increased challenging behaviours and more depression (Srivasta and Cooke, 2000), whereas others have reported decreases in challenging behaviours (Cooper and Picton, 2000).

To date the views of former hospital patients and of their carers have received relatively scant attention compared with the amount of detail collected from service staff about the characteristics of the people and changes in them since their move. Such information can serve a number of uses. It can help to validate the success of the resettlement policy and reassure relatives who may have concerns about people still in hospital who may move at a future date. Second, it will determine any shortcomings in the new arrangements and improve future service planning for those who have been resettled as well as those who may be resettled in the future. This is especially topical in Britain with imminent changes in the way 'preserved rights' benefits are to be treated.

Resettlement population

A total of 68 persons were resettled from the hospital over a 5 year period: 12 (18 percent) in 1996; 31 (46 percent) in 1997; 15 (22 percent) in 1998; nine (13 percent) in 1999; and one (1 percent) in 2000. Of the 68 persons resettled, 37 (54 percent) were male and 31 (46 percent) were female. By contrast, of the 107 patients in hospital awaiting resettlement, there were more males than females (68 percent and 32 percent).

The median age on discharge was 37 years (range 19 to 62 years). The median age of those remaining in hospital was also 37 years, but the range was from 22 to 92 years. Hence older people tended not to have been resettled in recent years. For the resettled group, the median length of stay in hospital was 8 years, with a range from 1 to 40 years. For those remaining in hospital, the median length of stay was 32 years (range 3 to 49 years). Thus the longer people had been in hospital, the less likely they were to move out.

Three people (5 percent) were reported to have Down's syndrome, seven (11 percent) had a diagnosis of autism, and one (2 percent) had cerebral palsy.

Information was gathered about the characteristics of the resettled patients from their present key workers. Based on their ratings on the Index of Social Competence (McConkey and Walsh, 1982), residents could be grouped into those with low dependency (N = 24; 36 percent),[1] those with high dependency (N = 22; 34 percent),[2] and those with a mixed profile, namely high dependency in some domains and low in others (N = 21; 31 percent).

Five persons (8 percent) had recurring fits and a further 17 (27 percent) had a history of epilepsy for which medication was taken but had no fits at present. Four persons (6 percent) had partial hearing and two (3 percent) were deaf for all practical purposes. Six people (9 percent) were unable to walk alone. One had partial sight and another was blind for all practical purposes.

In all, 27 people (40 percent) were considered to have a mental health problem, of which depression (N = 15), anxiety (N = 7) and schizophrenia (N = 5) were the most common. This proportion is higher than that reported in English studies (e.g. Emerson et al., 2000) and probably reflects the role that the hospital plays in treating people with mild or borderline learning disabilities who have mental health problems.

A total of 32 persons (50 percent) were reported to engage in one or more challenging behaviours, of which the most frequently occurring were aggression to others (N = 15), self-injurious behaviours (N = 11) and destruction of property (N = 8).

Type of accommodation

Decisions about community placements were made in consultation with the persons, their relatives and the hospital resettlement team. Care managers reported that around 60 percent of patients participated in these planning meetings and around 68 percent of family members.

A total of 60 persons (88 percent) moved to residential or nursing homes. Of these, 22 moved to one newly built residential home and another seven to a new facility specifically for people with autism. These two facilities accounted for 45 percent of the people relocated. The remainder were resettled in 21 other establishments. In addition, five people went to live in shared housing and two people went into a supported living service provided by an HSS trust. One person went to live with her family.

Of the 67 placements in residential accommodation, 35 (52 percent) were with the private sector, 22 (33 percent) in statutory provision and 10 (15 percent) with the voluntary sector.

In all, 63 persons (94 percent) moved to accommodation that was solely for people with learning disabilities. Of the remaining four in residential accommodation, one went to each of homes for the frail elderly, for deaf persons with additional needs, for persons with mental health needs, and for persons who are deaf/blind.

Overall the median size of the residential facilities was 19 places. The range was from single-person accommodation to a home with 72 registered places for the frail elderly; however, nursing homes had a median of 33 places (range 18 to 72). The largest facility for people with learning disabilities had 36 places, divided into four self-contained units with nine persons in each.

In all, 59 persons (87 percent) had their own bedroom after the move and nine people (13 percent) shared with one other person. Over two-thirds of persons in residential accommodation (N = 43) had rooms on the ground floor. Upstairs rooms were thought suited to all the people in them. Although 30 residents were reported to have a washbasin in their bedroom, only four persons had ensuite toilet and shower/bath.

Of the 68 people resettled, 59 (87 percent) continue to live in the place to which they moved. Four persons were back in hospital; three had moved to another residential home; and one had moved into their own tenancy from a residential home. One person had died 2 years after moving.

Method

All of the resettled population – bar the person who died – were followed up at least 1 year after their move: a total of 67 persons. Independent researchers gathered the information through either interview or self-completion questionnaires with residents and relatives similar to those used in previous studies (e.g. Emerson et al., 2000).

The project steering group advised on ethical issues. Formal ethical approval was not deemed necessary but steps were taken to ensure that participants gave informed consent. The reasons for doing the study were made clear, and participants were assured that all information given would be confidential to the researchers; that no one would be identified in any reports; that people could refuse to answer any question; and that their participation or not in the research would not affect the services they received. An information sheet in straightforward English was prepared giving this information in writing, with contact details if people had any queries after the interviews.

Informed consent was obtained from people with learning disabilities in the presence of their key worker or staff member in the present residence. Only those people whom both the researcher and key worker felt gave informed consent were included in the study.

Resident interviews

Of the 67 persons, 27 (40 percent) could not be interviewed owing to communication problems, though on a number of occasions an interview was attempted. Another person refused to give consent. In all, 39 persons (58 percent) were interviewed. A discriminant analysis, contrasting those people who had been interviewed with those who had not, yielded only one significant discriminating variable, namely dependency level.[3] Interviews were done with 96 percent of people rated by key workers as having low dependency; 60 percent of people rated as mixed dependency; and 18 percent of people rated as high dependency ($\chi^2 = 27.0, p < 0.001$).

Relatives questionnaires

Care managers of residents had been asked to forward a self-completion questionnaire to families. However, this yielded only 15 replies. Telephone interviews were then conducted with a further 17 relatives who were reported by the residential facility as having regular or frequent contact with the resident, plus one face-to-face interview with a family carer who looked after her relative at home. The total of 34 relatives who responded represents 58 percent of all known relatives and 69 percent of those relatives reported to have regular contact with the residents. The main reason for non-responses was a lack of telephone at home; wrong phone numbers; no recent addresses; and a failure to respond to the questionnaire.

A discriminant analysis was undertaken to examine possible differences among the relatives who were contacted with those we were unable to contact.[4] This yielded only one significant discriminating variable, namely length of time the person had been in hospital. The people whose relative had been contacted had been in hospital for a significantly longer time than those whose relatives were not contacted (mean 15 years versus 9.9 years;

$F = 4.0$, $p < 0.05$). These also tended to be people who were classed as high dependency.

Overall, information was obtained from either the person or their relatives for 56 of the 67 (84 percent) people in the resettlement population. Moreover proportionately more relatives of highly dependent people commented, while clients of lower dependency were interviewed.

Views of people with learning disabilities

Of those interviewed, 27 were living in residential homes, five in shared housing and four in nursing homes; two had their own tenancies, and one lived with her family. All of the residents in the nursing homes and supported accommodation named at least one thing they liked about their present residence, as did 26 of the 27 people in residential homes. These are listed in Table 1, which contrasts their responses when asked a similar question about the long-stay hospital. Many more people stated that they liked nothing about the hospital than they did about their present residence.

However, eight people commented on things they did not like about their residential home, as did two people living in nursing homes and two in supported accommodation. Their views are listed in Table 2, and again their dislikes are contrasted with those mentioned for the hospital.

People living in residential settings (38) were asked specifically what they thought about the staff and co-residents at their present place and at the hospital. In all, 30 persons (79 percent) liked the staff in their present residence, with the other eight persons (21 percent) stating they liked some and not others. Comparable figures for the hospital were 58 percent liking the staff and 11 percent liking some and not others. However, eight persons (21 percent) did not like any of the hospital staff and four persons made no comment.

A similar pattern held for their views on co-residents. In all, 71 percent stated they liked the people they presently live with; three (8 percent) liked some and not others; and two did not like any (5 percent). (Six people made no comment.) At the hospital, 47 percent liked their co-residents; 24 percent liked some and not others; and four people (11 percent) did not like any of them. (Seven people did not comment.)

When asked if they felt safe and secure in the two places; more answered yes for their present residence (87 percent) than for the hospital (70 percent). The former included all the people living in shared housing and own tenancies. Reasons for feeling not safe at present were being scared of other residents; living in an area that is not safe; and being frightened at night. Another commented that he 'used to be afraid; it took a while to get used to the new place'.

Table 1 **The number of people with learning disabilities mentioning their likes (more than one allowed) about their present residence and the hospital (*N* = 39)**

Likes about present residence	*N*	*Liked about hospital*	*N*
Friends	7	Friends	8
Outings	6	Staff	4
Staff	4	Good/alright	3
Food	6	Disco/dances	3
Like it	4	Picnics/BBQs	1
Quietness	3	Plays/concerts	1
Independence	3	Working in gardens	1
Freedom	4	Food	1
Community facilities	2	Felt better there	1
Co-residents	2	Quiet	1
Own TV	2		
Music	2	Nothing to like	16
Privacy	2		
Surroundings	1	No mentions	5
Building	1		
Clothes	1		
Downpatrick town	1		
Near home	1		
Go to work	1		
Smallness	1		
Multi-sensory room	1		
Boyfriend nearby	1		
Family here with me	1		
Social skills group	1		
Nothing to like	1		

These findings are broadly similar to a larger sample of resettled people in England studied by Cambridge et al. (2002).

Move from the hospital

Around two-thirds of people reported that they had requested a move from the hospital. Of the 36 persons answering the question, 33 (92 percent) said they were happy to move; two people did not want to move at first but they came round to the idea; and another was not really bothered. Twelve went on to give a reason for requesting a move: five because they did not like the hospital; two to get 'freedom'; two because the other residents 'get you down'; one to be nearer his sister; and one because it was 'time to move to a different place'. One person who did not want to move

Table 2 **The number of people with learning disabilities stating dislikes (more than one allowed) about their present residence and the long-stay hospital (*N* = 39)**

Dislikes for present residence	*N*	*Disliked about the hospital*	*N*
Staff	2	Didn't like any of it	5
Noisy	1	Food	5
Afraid of another resident	1	Hassled by others	4
Afraid at night-time	1	Not getting out	4
Laundry	1	Missing family/friends	3
Bored at work	1	Shared dorms	3
Visitors in and out	1	No freedom	2
Money not good	1	Staff	2
Lonely	1	People stealing things	1
Travelling to centre	1	Room	1
Don't go to Gateway Club	1	Throwing chairs	1
		Noisy	1
Nothing disliked	25	Too big	1
		Afraid of dark	1
		Lonesome	1
		No money or cigarettes	1
		Everything about it	1
		Nothing to dislike	5
		No mentions	7

said it was because she was happy in the hospital, and the other commented: 'I didn't want to move at first because I was afraid but I'm glad I did make the move.'

In all, 33 persons (85 percent) said they were glad they had left the hospital; two (5 percent) were not glad; and four did not comment. However, six people (15 percent) said they felt like moving back to the hospital, and another four persons (10 percent) felt like this sometimes. (However, only one person expressed a wish to move back to the hospital when asked about their wishes for the future.)

Over two-thirds (27 persons; 69 percent) did not feel like moving back. Equally a total of 31 people (80 percent) reported they were happier since leaving the hospital; two (5 percent) were unsure; and three (8 percent) were not happier (all three were living in residential homes).

When asked if they missed anything about the hospital, 11 persons (28 percent) made no comment and 14 (36 percent) said 'nothing'. The remaining 14 (36 percent) mentioned missing friends (N = 8), staff (4), activities such as discos (3) and the grounds (3). In all, seven persons (18 percent) mentioned things they did at the hospital that they could not do now. These included going to dances, going to Antrim town, ten-pin bowling, gardening and the town parade. However, most people (82 percent) could not think of anything they were not now able to do.

Friendships

Over half the people (21) reported having friends, but less than a quarter (nine people) reported having friends outside the residence; eight of these lived in residential homes and one person in a nursing home. In addition, two people living in a shared house had a befriender recruited by the service agency who took them to the cinema and similar outings. However, 12 people said they had no friends and five made no comment.

Activities

All mentioned a range of activities they did during the day. Attendance at a day centre was the most commonly mentioned (23 people), but people also went to college (N = 5), did vocational training (2) and did jobs around the residence (2). One person was on work experience, but no one had paid employment.

A wide range of leisure pursuits was mentioned when residents were asked what they did at evenings and at weekends. In the evenings, watching television (N = 25) and listening to music (15) were the most popular pursuits. In all, 19 people mentioned only home-based activities. Among the out-of-home pursuits were going to the pub/cafe (N = 7), going to the cinema (3), walking (3), watching football (2), shopping (2) and using a health club (1).

Weekend pursuits were more varied. In all, 34 people (87 percent) mentioned one or more activities that took them out of the house; the most common were going to the pub (N = 12), shopping (9), visiting relatives (6), going to the cinema (6), walks (5) and outings in car (4). In addition 26 people (67 percent) reported having been on holiday during the past 12 months.

Summary

People mentioned more things that they liked about their present residence than they named about the hospital and they had fewer dislikes than for the hospital.

Nearly all were happy to have moved. Only one person said they had not wanted to move from the hospital, and another wished they could move back there.

Nearly all the people had some form of day activity programme and most reported a variety of evening and weekend activities both in and outside the residence. Half the people interviewed reported having friends, with one-quarter having friends from outside the residence.

Views of relatives

Reactions to the move from the hospital

Of the 34 relatives contacted, 21 (62 percent) said they were happy to consider a move from the hospital, but nine relatives (26 percent) were unhappy with the prospect of the move. Among the reasons they gave were:

> N. was happy and settled there.
>
> I was unsure how he would adapt to the move as he had been so many years at the hospital.
>
> He had been in hospital for so long: we felt he was too aggressive to move out.

Four relatives (12 percent) had no strong views either way. One mother commented:

> I felt a bit torn – pleased with the hospital but assured the move would be good for N.

All but five families (N = 29; 85 percent) said they had been satisfied with their involvement in planning the move, but only one-third (12; 35 percent) reported that they had been offered alternative placements.

Present placement

In all, 28 relatives (82 percent) felt the placement was very well suited to their relative's needs; five (15 percent) that it was reasonably well suited; and one (3 percent) that it was not suitable and that the person needed to move, but no reasons were given.

Also 28 families (82 percent) rated the service very much better than the hospital; three (9 percent) rated it as much the same; and no-one said it was worse. (Three families did not comment.)

The things which two or more families mentioned as liking best about the present residence are listed in Table 3. Two families were unable to comment, as they did not visit their relative in the residence.

Families appear to judge the facility mainly in terms of the helpfulness of staff; its homeliness and standard of accommodation; and their relative having a room of their own. Relatives also mentioned other things they liked, including the residence being near shops and facilities; having an all-female unit; and their relative being with people who could talk.

Table 3 **The number of relatives mentioning features (more than one allowed) of present accommodation that they liked (*N* = 33)**

Features liked	*N*
Staff: friendly, efficient, more of them	19
Modern building	13
Atmosphere of place; homeliness	12
Own room	10
Day care/activities provided	6
Relative is happier there	6
More freedom and independence	5
Close by relative's home	4
Friends and social life	4
Good food	3
Outings provided	2
Clean and hygienic	2
Treated as a person/individual attention	2

Fifteen (45 percent) of the 33 relatives mentioned one or more things they would like to see improved. The most commonly mentioned were having more activities for their relative (N = 5), more information from staff (3), more staff (2) and less turnover of staff (2). Among the other improvements they noted were having more privacy on visits to the residence; relative having their own room; forming a parents' group; reviews being held; medical checkups; speech and language therapy; more socializing; relative having a job; moving to more independent living; improved personal hygiene and appearance; receiving payment for work done in day centre; and receiving training in independence.

Most relatives made further comments; a selection follows.

> This home has been the best my brother has had. He seems happy, he is more talkative than when he was in hospital.
>
> My relative has lived in her present situation for 18 months and there has been a vast improvement in her attitude and her general wellbeing.
>
> In comparison to the hospital we are very happy with the current placement but there are some aspects we would like to see improved. Our daughter does seem happy. She has complex needs but the staff are very tolerant when she is going through a difficult phase.
>
> N. has improved dramatically since his transferral, both physically and mentally, due in part I feel to a much more caring environment. Any negative happenings have been due to a lack of staff.

> Pity there is not more places like [residence]. The Board was completely unhelpful about the provision of a new place that N. could move to. I had to locate somewhere myself. I took on the system and won.
>
> The weekends need to be planned to have more activities, such as exercise. The staff changeover is too high. There are too many people in the building and it is quite institutionalized.
>
> When people go into a home the parents are sometimes not thought of. The whole family changes. Social workers get less involved once the person is admitted. Parents need more information.

Walsh et al. (2001) report broadly similar findings with relatives of nearly 300 people with learning disabilities in a range of residential provision in Britain and Ireland. Moreover in this study, parents' views did not vary significantly by type of accommodation.

Summary

Although a majority of relatives welcomed the move from the hospital, a significant minority (26 percent) had been unhappy at the prospect of the move. After the move all relatives felt the residence was at least equivalent to the hospital, with over four out of five relatives rating it as much better than the hospital.

Only one-third of relatives reported that they had been offered an alternative to the present placement.

The features relatives liked best about the present residence were the staff; the homely atmosphere; the buildings; and their relative having their own room.

The aspects they felt required improvement were more activities for the residents; better communication with staff; having more staff available; and lower staff turnover.

Discussion

The views of the people who were resettled and of their relatives confirm the conclusions of Emerson and Hatton regarding the outcomes from previous resettlement programmes in these islands:

> The move from more to less institutional environments is associated with improvements in material standards of living, increased user satisfaction, increases in adaptive behaviours, increased participation in community-based activities and increased contact with family and friends. (1996, p. 30)

Improved material standard of living is evident from the numbers of people having their own bedroom instead of the dormitory-style accommodation of the hospital, and they are living with smaller numbers of people. Their relatives also commented on the homeliness of the surroundings and the modern buildings.

Increased user satisfaction is clearly present. The residents themselves are happier, mentioning many more things they liked and fewer dislikes compared with the hospital. Nearly all their relatives rated the present placement as better than the hospital, even those who were initially unhappy at the prospect of their relative moving. Indeed Emerson et al. note that parents are often satisfied with existing services, be it hospital or community-based services, but they go on to note that 'following their relative's move to community-based services, relatives rate these services highly and, in retrospect, tend to express preference for the new arrangements' (2000, p. 112).

Although the study was not able to document increases in adaptive behaviours and in contacts with the community and family, these can be inferred from comments made by residents and relatives. For example, most of the people have access to community facilities; many have trips out with their family; and some stay overnight with them.

Shortcomings of the resettlement programme

These positive outcomes have to be set against a number of shortcomings which are implicit in the comments expressed by the residents and relatives.

Nine out of 10 people moved into residential and nursing homes ranging in size from six to 72 beds. This proportion is only marginally lower than the 98 percent of people in a previous resettlement study in Northern Ireland (Donnelly et al., 1997) who moved into similar accommodation between 1990 and 1992. In that study a much higher proportion of people went to nursing homes compared with the present population, but there were financial incentives for doing this in the early 1990s. These percentages are much higher than those reported for past resettlement programmes in Great Britain (Cambridge et al., 2002).

Supported living models have not been used to any great extent for resettlements, despite the benefits which this model of housing and support has been shown to offer people with learning disabilities over other forms of accommodation (Emerson et al., 2000). Indeed service users are likely to be unaware that such options could be available and therefore they are only able to judge present arrangements against the hospital experience rather than on what could be available. Ongoing research has found that people with learning disabilities and their relatives prefer supported living arrangements to residential homes (McConkey and McConaghie, 2001).

A second shortcoming is the failure of people to move on from their community placement. Over a third of the sample were deemed to be of low dependency, and the key workers had identified 13 people whom they thought required a different type of placement to residential and nursing homes, mostly into more independent living arrangements. Likewise this was the option most commonly mentioned by care managers if the existing placements were no longer available (McConkey et al., 2000). However, it appears that a move has happened for only one person since they moved from hospital, with plans for another two people to follow this option.

What is it that keeps people 'trapped' in inappropriate settings? In the past, explanations revolved around the perverse incentives associated with preserved rights payments. This is not the case with these resettlements. A number of interrelated factors could be proposed: the predisposition of professional staff to stick with 'tried and tested' models of care; the lack of immediate support for people in more independent settings; and the fears of relatives and even the individuals themselves.

However, these same issues probably surrounded the initial placements from hospital and were worked through then. Thus the changing capabilities and aspirations of the residents must be reflected in regular reviews of needs and updated care packages, with residents having access to independent advocacy services to ensure their needs are addressed, as recommended in the recent White Paper *Valuing People* (Department of Health, 2001). This is especially crucial with the present resettled population, of whom half are under 37 years of age and the youngest is 20 years old.

A third common failing of many resettlement projects has been the inability to create social networks of acquaintances and friends for the people with learning disabilities. Fewer than one in four residents claimed to have friends outside the residential homes, and these were mainly other people with learning disabilities. Cambridge et al. (2002) also note the restricted social networks that exist 12 years after people are resettled from hospital.

A number of factors can contribute to this: their prolonged stay in hospital; the geographical isolation of the residence from the person's home area; and the inability of the person to travel independently. In addition the priority of commissioners of services and of registration and inspection units has been on the physical wellbeing of residents rather than on their social inclusion. However, a number of agencies have started to develop befriending schemes as a means of building up residents' involvement in community activities and extending their social networks. These and other efforts, such as reviewing the job descriptions of support staff, should feature in future resettlements.

Perhaps the clearest message to come from both residents and the relatives is the importance of staff in their satisfaction with services. Arguably this can outweigh some of the other disadvantages of various settings. Thus the primary goal must be to recruit and retain high calibre staff irrespective of the settings where they work.

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Notes

1 Typically they are able to communicate through speech and to understand instructions; are able to look after their personal care needs; and have basic reading, writing and numerical skills.

2 Typically they have poor communication skills; are dependent on others for their self-care; and are unable to read and write, with little or no understanding of numbers.

3 The variables entered into the analysis were age, gender, length of stay in hospital, dependency level, number of problem behaviours and mental health problems.

4 The variables entered into the analysis were age, gender, present residence, length of stay in hospital, dependency level, number of problem behaviours and mental health problems.

References

BAILEY, N. M. & COOPER, S.-A. (1997) 'The Current Provision of Specialist Health Services to People with Learning Disabilities in England and Wales', *Journal of Intellectual Disability Research* 41: 52–9.

BRADDOCK, D. (1999) 'Aging and Developmental Disabilities: Demographic and Policy Issues Affecting American Families', *Mental Retardation* 37: 145–54.

CAMBRIDGE, P., CARPENTER, J., BEECHAM, J., HALLAM, A., KNAPP, M., FORRESTER-JONES, R. & TATE, A. (2002) *Twelve Years On: Outcomes and Costs of Community Care for People with Learning Disabilities and Mental Health Problems*. Canterbury: Tizard Centre.

COOPER, B. & PICTON, C. (2000) 'The Long-Term Effects of Relocation on People with an Intellectual Disability: Quality of Life, Behaviour and Environment', *Research in Social Work Practice* 10: 195–208.

DEPARTMENT OF HEALTH (2001) *Valuing People: A New Strategy for Learning Disability for the 21st Century*. London: HMSO.

DONNELLY, M., MCGILLOWAY, S., MAYS, N. ET AL. (1997) 'A Three to Six-Year Follow-Up of Former Long-Stay Residents of Mental Handicap Hospitals in Northern Ireland', *British Journal of Clinical Psychology* 36: 585–600.

EMERSON, E. & HATTON, C. (1996) 'Deinstitutionalization in the UK and Ireland: Outcomes for Service Users', *Journal of Intellectual and Developmental Disability* 21: 17–38.

EMERSON, E. & HATTON, C. (2000) 'Residential Supports for People with Learning Disabilities in 1997 in England', *Tizard Learning Disability Review* 5: 41–4.

EMERSON, E., ROBERTSON, J., GREGORY, N. ET AL. (2000) 'The Quality and Costs of Village Communities, Residential Campuses and Community-Based Residential Services for People with Learning Disabilities', *Tizard Learning Disability Review* 5 (1): 5–16.

GRIFFEN, T. & PARMENTER, T. R. (1999) 'Institutional and Community Living in Australia', *Tizard Learning Disability Review* 4: 39–43.

MCCONKEY, R. & MCCONAGHIE, J. (2001) *An Evaluation of Support Living Accommodation Provided by Triangle Housing Association*. Ballymoney: Triangle Housing Association.

MCCONKEY, R. & WALSH, J. (1982) 'An Index of Social Competence for Use in Determining the Service Needs of Mentally Handicapped Adults', *Journal of Mental Deficiency Research* 26: 47–61.

MCCONKEY, R., MCCONAGHIE, J., MEZZA, F. & WILSON, J. (2000) *Moving on from Hospital: The Outcomes and Lessons as Perceived by People with Learning Disabilities, Their Key-Workers, Care Managers and Relatives*. Belfast: EHSSB.

SRIVASTAVA, A. K. & COOKE, Z. M. (2000) 'Changes in the Quality of Life of People with Learning Disabilities Six Months after Transfer from Long-Stay Hospital into the Community', *Tizard Learning Disability Review* 4 (3): 40–4.

WALSH, P. N., LINEHAN, C., HILLERY, J., DURKAN, J., EMERSON, E., HATTON, C., ROBERTSON, J., GREGORY, N., KESSISSOGLOU, S., HALLAM, A., KNAPP, M. & JAERBRINK, K. (2001) 'Family Views of the Quality of Residential Supports', *Journal of Applied Research in Intellectual Disabilities* 14: 292–309.

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NOT TO BE TAKEN AWAY

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Cancer and People with Learning Disabilities: The Evidence from Published Studies and Experiences of Cancer Services by J. Hogg, J. Northfield and J. Turnbull. Kidderminster: British Institute of Learning Disabilities, 2001. ISBN 1-902519-73-6. £10.00 plus £1.00 p&p. 57 pp.

This report is a 'must have' for all professionals and organizations who are charged with responsibility for delivering care to children and adults who have a learning disability. More tricky but just as essential is how the information within this report is disseminated to mainstream professionals in primary and secondary healthcare, and mainstream cancer specialists. I believe that during the last 7 or 8 years there has been a growing unease within the professions that cancer care and cancer prevention has been somewhat neglected. This report justifies this unease in the case of learning disabled individuals.

The report itself was commissioned by the Department of Health to provide background material for the English White Paper *Valuing People: A New Strategy for Learning Disability for the 21st Century* (Department of Health, 2001) and I truly hope that the Department takes cognizance of some of the dramatic findings and the sensible recommendations.

The review is divided into two sections. The first is primarily a literature review which provides some surprising findings. For example, morbidity and mortality from cancer in the population of people with learning disability is some way behind those caused by respiratory and cardiovascular conditions. However, the authors do point out that conclusive epidemiological information is missing, and particularly so in community settings. One of the strengths of this section is that worldwide studies were