Carers Involvement in Discharge

Health and Care Act April 2022- gives new rights to involve Carers and people who use services. The act will place new duties on NHS England and the new Integrated Care Boards to involve Carers strategically through public engagement. It also introduced new provisions requiring involvement with Carers ,where appropriate, in relation to any services for the prevention, diagnosis, care and treatment of the person they care for. Key responsibilities for NHS trusts to involve Carers (including Young Carers) in the process of hospital discharge.

Carers are the experts that can help shape services and support

Over half of Carers were not involved in decisions about discharge- Carers UK 2021

Patients being discharged in the middle of the night

Not having the right equipment on discharge

Carers not being informed the person they are caring for is being discharged

Long waits for discharge for one day hospital stays

Carers are not being involved in discharge planning

Carers are not being asked if they will cope resulting in crisis

Timeline of Discharge to Assess Home First Approach

Definition of Discharge to Assess: Where people who are clinically optimised and do not require an acute hospital bed, but may still require care services are provided with short term, funded support to be discharged to their own home (where appropriate) or another community setting. Assessment for longer-term care and support needs is then undertaken in the most appropriate setting and at the right time for the person.

April 2020

Came into effect at the beginning of the Covid-19 Pandemic

1. **Discharging people from hospital the day they have the right to be discharged**

2. **Ensure everyone has a personalised plan on discharge. Focused on recovery.**

3. **Assessing people within 4 weeks where they may require longer term care and support**

April 2022

- In elective care, early discharge planning should start before admission.
- For emergency care, planning should start on day 1 including the setting of an expected date of discharge.
- **Involvement of individual, their Carer(s) and family.**
- Record the clinical criteria for discharge.
- Red to Green approach twice daily working towards discharge and checking the criteria to reside in hospital
- Get up, dressed and moving every day by embedding "End of PJ paralysis".
- Multidisciplinary / multiagency discharge teams, soon to include the voluntary and community sector
- Discharge Hubs to ensure patients get the right support
- Moving towards 7 day services
- Transfer of Care Form
- Focus on Choice – A robust protocol underpinned by fair and transparent escalation process so that people can consider options before reaching decisions about their future care.
- Enhancing health in care homes.
- Use of the virtual ward.

Click here to read the hospital discharge and community support guidance

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Home First Hubs

- 3 hubs in Norfolk- Central, East & West
- Consists of different health and social care professionals
- Staff in hospital complete transfer of Care form given to Home First Hub who complete triage and decide which D2A pathway is required
- Assistant Practitioners are allocated to progress discharge
- Steps undertaken to understand perspectives of the person, Carers & families and for all to be involved in the discharge process .

Transfer of Care Form

Completed by hospital staff and sent to the Home First Hubs. Includes:

- Reason for admission
- Social details
- How the person previously managed
- How they are presenting on the ward and what their current needs are
- What the persons wishes and goals are for discharge

Pathway 1 - to intermediate care and reablement services provided in their own homes

Pathway 2 - to residential care within the independent and community sector

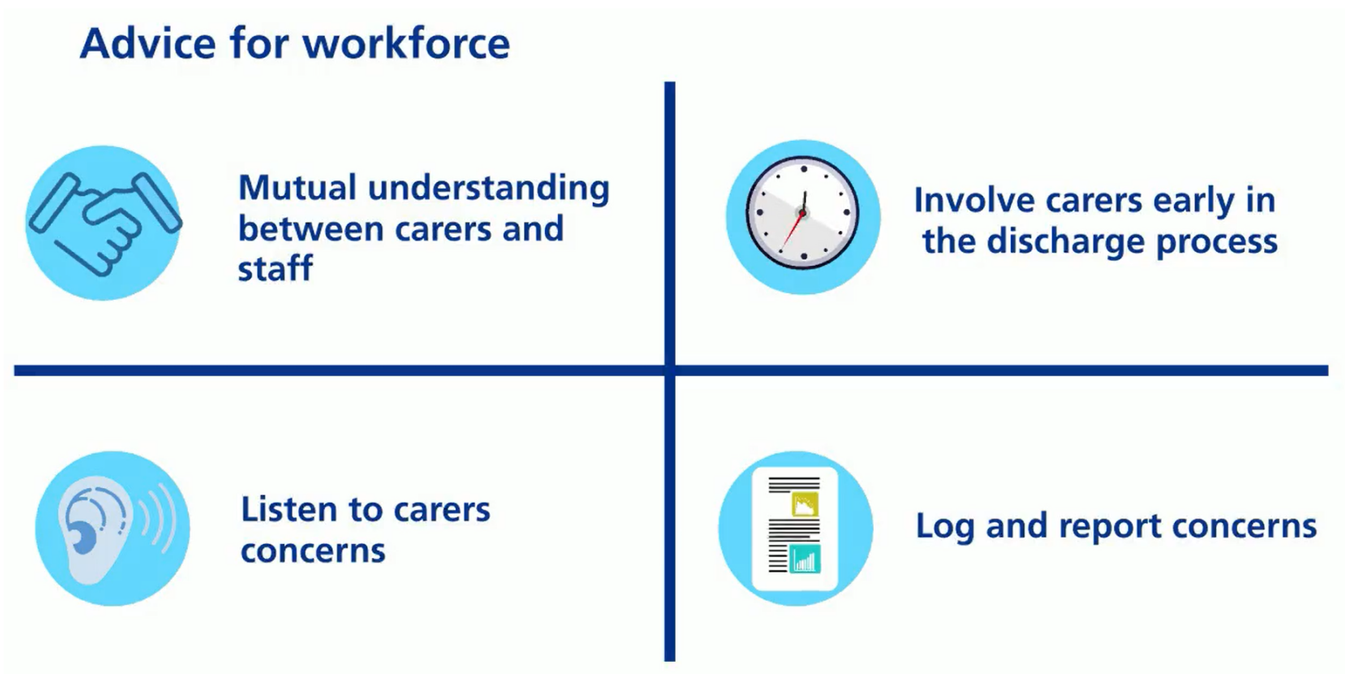
Pathway 3 - to nursing care within the independent sector

Discharge

- Once everything is being co-ordinated for discharge, a discharge date is set with involvement from Carers and families
- When the Home First Hub receive confirmation of discharge, referrals are then made on to the relevant health and social care teams for assessment to take place in their own environment

Then transferred to a Follow Up team:

- Care Act Assessment
- Arrange longer term plans for support



Crisis situations arise as a result of not listening to what Carers were saying during discharge planning

Long waiting lists for services & assessments

Carers are not asked if they have caring responsibilities when admitted into hospital and whether they will be able to cope with these when discharged.

Carers feel like people are being discharged to free up hospital beds

Carers shared feedback about their concerns not being listened to

Once Community services know they have friends and neighbours they look no further as to longer term support needs

No information given on discharge

Not the same process across the acute hospitals

No one checking to see if support is in place for the person they are caring for whilst in hospital

Next Steps/Recommendations:

- Discharge Task and Finish Group to be led by Carers Voice 👍 Agreed by Conference attendees
- Information page about discharge, what to expect and the different pathways to be be shared on the Integrated Care System website.
- Transfer of Care Form- ensure Carers are asked about their own support needs
- Consistent service across the Integrated Care System

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