

Carers and Hospital Discharge

2nd November 2023



Carers and Hospital Discharge toolkit

Recognising, valuing and involving unpaid carers throughout the hospital discharge journey.



The Carers Perspective

Dame Philippa Russell DBE

Chair

Dame Philippa Russell DBE is the Chair of the former Standing Commission on Carers, Vice-President of Carers UK and the Topic Adviser for the NICE Guideline on Support for Adult Carers. She is a member of the Programme Board for the Think Local Act Personal Partnership (TLAP) and of the TLAP National Co-Production Advisory Group, representing carers' interests. Philippa was formerly a Commissioner with the Disability Rights Commission and Director of the Council for Disabled Children.

Philippa is the parent of a son with a learning disability and has wide contacts with voluntary and user organisations with an interest in disabled children, young people and their families.





Introduction to the London Carers and Hospital Discharge Toolkit

The Health and Care Act 2022 - Section 91

- Places a duty on NHS hospital trusts to ensure that unpaid carers of all ages are involved as soon as feasible when plans for the patient's discharge are being made.
- The new statutory guidance is clear about the need to ensure that carers and young carers are identified, kept safe during the discharge process and signposted to sources of help and assessment of their needs. The guidance also highlights the need to “ensure that no carers are left without adequate support or an assessment of their longer-term needs (if needed).”



NHS E&I Healthwatch Carer Experience of Hospital Discharge Project

Impact of [Report](#) May 2022

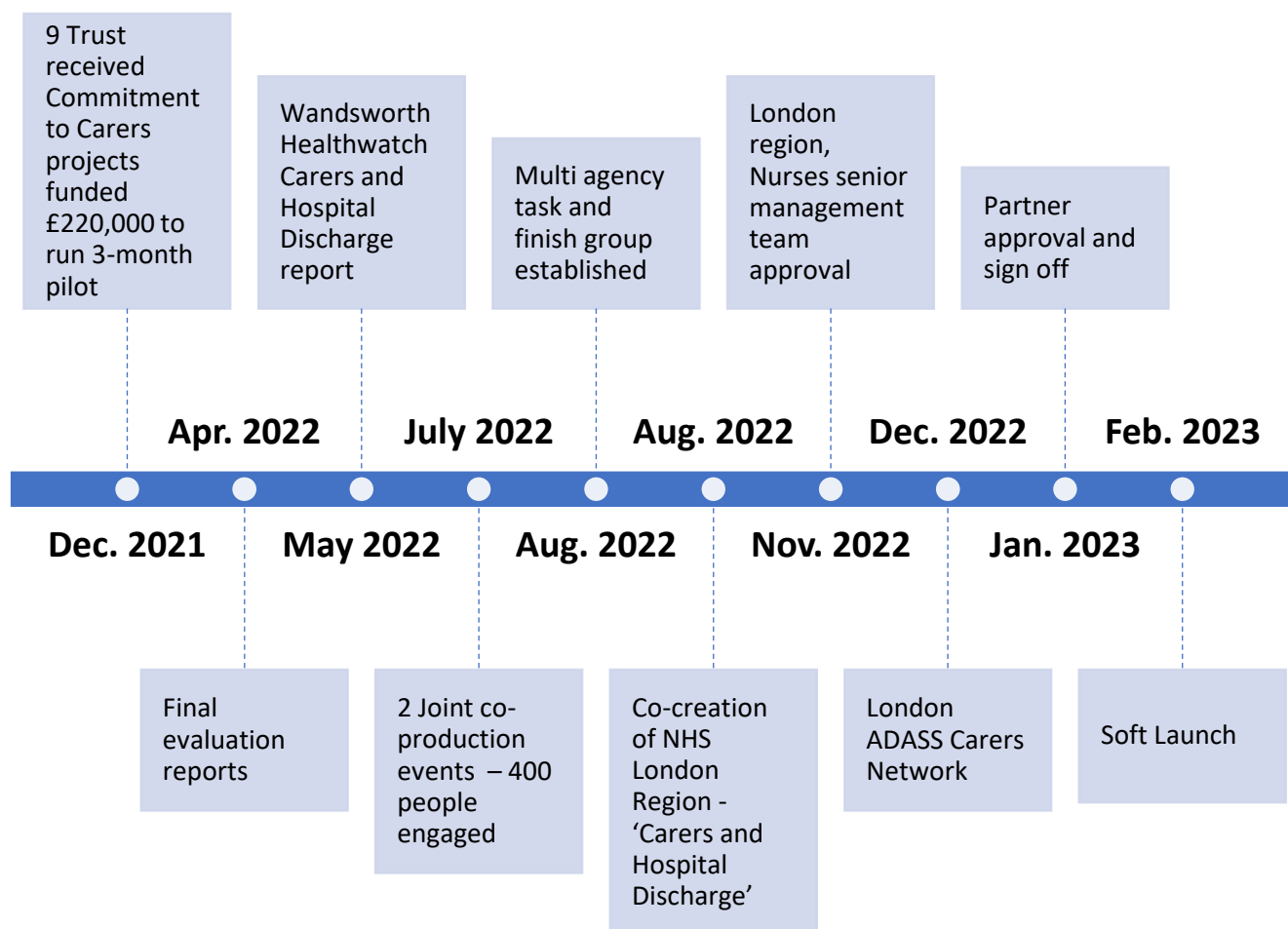
healthwatch

Carers and Hospital Discharge

Toolkit for London Hospitals and Community Providers



A collaborative journey



Carers Pathway

- 1 Identification
- 2 Welcome and recognition
- 3 Assessment and support
- 4 Involvement
- 5 Transition

Carers Care Pathway

The **Surrey Carers Pathway** is a way of helping to ensure carers receive the type of support they need at the right time. The **Surrey Carers Pathway** was designed to serve two purposes: to fit within existing pathways familiar to community health care and hospital staff, and to help health care staff identify, recognise and support carers. There are other carer pathway models used elsewhere in the country and these are all very similar.

The five-step pathway was originally co-designed by carers and professionals in Surrey in 2015 and was updated in 2021.

The pathway has been reviewed by the NHS England London region health and social care partners, in the light of the recent guidance and additional steps identified. Providers will need to consider who is responsible for delivering each part of the pathway.

Carer is informed they have the right to a statutory carer's assessment of their own needs. The benefits of this are explained. Support needs of the family and children are identified.

Carer is referred to the local carers support service or given information on how to self-refer.

Staff ensure carers are given the practical skills and training to allow them to care.

Carers have seamless experience when moving through service(s).

Assessment and Support

Transition

Involvement

Identification

Welcome and Recognition

Carer is identified at the earliest possible stage and their details recorded. Carer confirms they are willing and able to care.

Any children in the household who might take on a caring role are identified.

Any parent carer who provides care for a disabled child for whom the person has parental responsibility.

Carer is welcomed.

The carer is given advice and information.

Carer is given the name of a member of staff who they can speak to when needed.

Advice is given to carer about the partnership approach to delivering care where the patient, carers and health and social care professionals are all seen as equal partners.

Step One Identification

Identifying carers is the first step to providing them with the support they need to maintain their own mental and physical health and wellbeing. A key barrier to providing information and support for carers is that they are frequently not identified. People may not see themselves as carers, either seeing caring as an extension of their family role, or as a good neighbour or friend. As both the care recipient and those involved with them, supporting friends and family to recognise their caring role and that the care recipient has the right to care and provides access to a range of advice, information and support. In addition, becoming a carer can be a gradual process, and carers may not recognise the changing nature of their relationship with the person they care for. Initially, many carers are not identified to health or social care professionals. These are commonly termed 'unseen' or 'invisible' carers. They do not access the support available, often because they do not know to look for it, or in relation to young carers, the other barrier is that they may often not be seen by health and social care professionals, because they are at school/work.

That is why having systems and processes to help identify potential young carers in place and adopting the principle of professional curiosity is so important.

Additionally, health and care staff may use the term 'unseen' or 'invisible' carers to describe a care worker or as the person who is recruited as 'lead' or 'key' contact with support services.

With 7 out of 10 cases starting their caring journey in an NHS setting there is a clear opportunity for health staff to support carer identification.

It is the responsibility of the admissions staff to provide the person and their family, carer or advocate with an opportunity to discuss their care. They should also provide the following information:

- reason for admission
- how long they might need to be hospitalised
- what care options are available that can support them when they can expect to leave the hospital or any special arrangements to support carers, for example the hospital's Patient Advice and Liaison Service (PALS). If the hospital has a care shower or individual care unit, a carer should be invited to visit the unit.
- if a care recipient is in a specialist unit, what that unit is and what services are available for carers, such as support groups, respite care, day care, etc.
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Step Two Welcome and recognition

Carers can struggle for recognition and support when they have a care recipient in hospital. It is a legal duty for local authorities to provide information to carers and carers to support them in their caring role. Information provided must meet the requirements of the Care Act 2014, Part 19 and Children and Families Act 2014. The local authority must ensure carers are identified and provided with information regardless of setting.

Carers are often the only part of the care team to know the care recipient's history, so it is not surprising that carers and their care needs are not going to be achieved if the outcomes are not met.

Following a systematic review study conducted by American Association of Retired Persons (AARP) where they compared discharge planning in rural care transitions with those where the carers had been hospitalised, these were associated with a 20% reduction in hospital readmission.

It is important that hospital staff have a good understanding of the rights and the benefits for carers so that they are able to explain them. People can struggle to exercise their rights if they receive unclear advice.

Information for carers should be:

- clear, concise, regularly reviewed and meet the NHS Accessible Information Standard
- clearly worded, easily processed and free of jargon
- personalised, set down in manageable chunks of information which use visual aids or pictures
- culturally sensitive
- respecting carers' rights and the need to access social and community support for carers
- covering useful contact numbers of information and support both for the local carers support service.

Step Three Assessment and support

Although the legal duties to assess carers support needs rest with local authorities there are many ways in which health staff can support the process. A key role is to ensure carers know they have a right to an assessment and how to request one. Staff can also ensure that carers know about rights for young carers.

Carers are often uncertain with how to care and may need support in managing the practical side of their care. Staff should not only help to use the range of tools available to help identify health goals and seek to transfer skills and knowledge to carers when appropriate as related to them.

For example, carers can be better understanding of:

- the condition, disability and needs of the patient
- physical and cognitive health
- safe moving and handling, including using equipment and adaptations
- specific information about staying safe in the caring role
- financial advice including benefits and allowances and information and support for self-funders and when the patient meets eligibility criteria for information on local funded and contributory health care funding.

For many carers a period of hospitalisation provides the first real break they have had from caring in many years. Staff should ensure a comprehensive assessment around the caring role is undertaken and that the carer is able to use this time to have a much needed break. Sometimes carers may need to be supported to do this and be told, as rarely as possible, that it is good for them to take a break and that the hospital staff can help to take care of the patient.

What is a statutory carer's assessment?

A carer's assessment is for carers over 18 years old who are looking after another adult over 18 years old who is disabled, or elderly. It is an opportunity to assess the impact of caring on the carer's life and what support or services they may need. The assessment will look at, for example, physical, mental and emotional needs, and whether they are able or willing to carry on caring.

What is a statutory young carer's assessment?

A young carer's assessment should be part of the whole family approach.

The local authority has a duty to assess 'in the circumstances of need' (i.e. without a risk of harm) to be made, although they must also be provided the young carer in the parent's interests and the assessment must involve the carer with their responsibilities, their parents and any other person the young carer identifies in the assessment process.

The assessment must look at:

- whether or not the young carer wishes to continue caring
- whether it is appropriate for them to continue caring
- any educational, training, work or recreational activities the young carer has been involved in

Step Four Involvement

When consent has been provided, staff and carers working together in good partnership with the patient's input their collective knowledge and expertise can be used to deliver individual care and support plans to help support necessary for the whole family.

A member of the hospital based multi-disciplinary team should be made responsible for providing carers with information and support. This could include:

- printed and digital information
- face-to-face meetings
- phone calls
- in-person training, including practical support and advice.

What should happen before hospital discharge from the carer's perspective?

- The carer and the person they care for can both be clearly involved, so long as the patient provides consent. When the patient refuses consent to provide information with the carer this choice must be recorded with the patient to ensure the health professionals and support. Regardless of consent the carer will be supported to share their right and has the right to receive general information as well as being offered advice to their support and for a carer assessment.
- A discharge assessment should be carried out to see if they need support once discharged.
- A carer's assessment should be carried out (or at least arranged), to see whether the carer will need support once the patient is discharged.
- Encourage the carer to consider completing an advance care plan in case anything happens to the care recipient that means they are unable to care. This will usually be arranged by either the local authority or an advance care plan in place of the local authority.
- A written care and support plan should be given to the patient and the support plan for the carer if they have had a carer's assessment or review of their carer assessment during the period of hospitalisation, which outlines the support required and how this will be provided. Make this available as a home care planning for carers.
- The carer and the person they care for and support plan for the patient and the support plan for the carer should be in place. This should include any care contingency plan. It is important that a carer contingency plan is completed with the carer's GP practice using ENHANCED CT Care under 0203020000000000. This should be available to all and allow first responders to activate the plan during for continuity of care to be used for patient.

Step Five Transition

A safe transition of care to the carer should be given the same status as any other transfer of care.

The discharge coordinator or the designated member of the MDT should arrange home care. This should identify practitioners from primary care, community health, social care, housing and the voluntary sector and staff who will provide support when the patient is discharged and record their details in the discharge plan.

The discharge coordinator should discuss the need for any specialist equipment and support with primary care, community health, social care and housing professionals as well as discharge planning staff. This includes housing adaptations. Ensure that any specialist equipment and support is in place at the point of discharge. This should involve the carer and equipment and support in place at the point of care might have in using the equipment.

Once assessment for discharge is complete, the discharge coordinator should arrange the plan for ongoing transition and support for the carer to ensure a smooth transition to the community based multidisciplinary team.

Staff should discuss with the person how they can support their condition after their discharge from hospital. Provide support and education, including training, if needed, to ensure the carer is able to support their condition. Training might take place at the hospital or in the community or at the carer's home.

When a patient is discharged for a virtual ward change to the use of any digital monitoring or use of assessment tools, the transfer should be planned in the ward, the Shared Services, Society, and the use of technology-enabled care, with special attention to patients and carers who may not have comfortable digital monitoring.

Discharge hospital care home: Virtual wards and hospital at home for older patients

The community-based MDT should ensure the carer's training and support needs regarding care in the community of the patient's care needs and what needs they have around the fact that they need to change care home.

Context

This resource has been created as a toolkit for London hospitals and community providers and provides action-orientated 'Top tips' for good practice, aimed at improving outcomes for all carers through their hospital journey.

The toolkit attempts to bridge the operational and realisation gap between the new hospital discharge and community support guidance (March 2022 updated July 2022) and the Supporting information for integrated care systems (ICS) leads Enablers for success: virtual wards and hospital at home (April 2022) guidance.

TOP TIPS

Supporting information for integrated care systems (ICS) leads Enablers for success: virtual wards and hospital at home (April 2022) guidance

Hospital Carers Checklist Tool

Step 1

Have you identified the recognised carer who is looking after your patient?

- Yes
- No

Are there any children in the household who are providing care or who may be affected?

- Yes
- No

Have you asked the patient if they are a carer?

- Yes
- No

If yes ask if arrangements have been made for the person/s they care about?

- Yes
- No

If no have you made a referral to social care?

- Yes
- No

What support have you provided to the carer? For example

- recorded carers details in hospital records
- involve carer in planning
- involve carer in care planning
- offer carer passport
- provide advice on patient medication and care
- provide carer information pack
- refer carer to local carers support services

Anything else

Hospital Carers Checklist Tool

Step 2

Have you checked the carer is willing and able to care?

- Yes
- No

Have you provided the carer (or a young carer and their family) with relevant information?

- Yes
- No

Step 3

Have you referred the carer to:

Social Care – Carer's Assessment

- Yes
- No

And / or

Local Carers Services

- Yes
- No

NB this includes any young carers identified.

Step 4

Has the carer been able to input in the discharge planning?

- Yes
- No

Has it been ascertained whether the carer is willing and able to provide care post discharge?

- Yes
- No

If the patient's care and support needs have changed during the period of hospitalisation has the carer been made aware of this? Are they still willing and able to care?

- Yes
- No

If the patient is being discharged to a different care setting has the carer been given information of what options are available to them and sufficient time to investigate these?

- Yes
- No

Step 5

Have the transport requirements of the patient been discussed with the carer?

- Yes
- No

Has the carer been informed what time to expect the arrival of the patient?

- Yes
- No

Has the carer been given advice and information on patient's medication?

- Yes
- No

Has the carer been provided with a copy of the discharge plan?

- Yes
- No

Has the carer been provided with a named contact and contact number to call if they have any concerns post discharge and does this cover out of hours services?

- Yes
- No

Hospital Carers Checklist

But what about Mental Health?

- Key points of law set down in the Health and Care Act apply equally to Mental Health Trust. According to the DH website *“Discharges from mental health hospitals are not within the scope of this guidance. However mental health trusts are encouraged to embed some of the principles, adapted for mental health care pathways. Separate guidance will be published for those being discharged from mental health settings in due course.”*
- This promised guidance for Mental Health would also be issued under the Health and Care Act (as with the main Guidance). The same duties to cooperate also apply with regard to the Care Act 2014, Children Act 1989 and Health and Care Act 2006.
.....And why would we treat Mental Health carers differently to any other carers. This would be discriminatory!
- [Mental Health Act 1983 Code of practice](#) (243 references to carers) last updated 2017
- NICE Guidance 108 - [NICE guideline on decision-making and mental capacity](#).
- NICE Guidance 53 – [Transition between inpatient mental health settings and community or care home settings](#)
- NICE Guidance 150 – [Adult Carers Support](#)
- Triangle of Care 6 standards – Best practice

Carers and Hospital Discharge toolkit

Weblinks:

- <https://www.england.nhs.uk/london/our-work/carers-and-hospital-discharge/>
- [Carers and Hospital Discharge Toolkit for London Hospitals and Community Providers - Resources - Carers Trust](#)
- <https://carers.org/news-and-media/news/post/251-how-a-new-toolkit-will-improve-the-hospital-discharge-experience-for-patients-and-their-family-carers>
- <https://www.carersfirst.org.uk/news-and-stories/launch-of-new-hospital-discharge-toolkit-for-carers/>
- <https://enfieldcarers.org/carers-and-hospital-discharge-toolkit/>
- <https://www.carers-network.org.uk/help-and-advice/news-and-updates/post/67-carers-and-hospital-discharge-toolkit>
- <https://organisations.mobiliseonline.co.uk/mobilise-nhs-hospital-discharge-toolkit>



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CARER

Case Study

Better Together – a collaborative service offer for unpaid carers

Impact of the London Carers Hospital Discharge Toolkit to date

In figures:

- <1050 unpaid carers since launch in February 2023
- Cost saving of £225 in bed days saved per carer who completes the support pathway
- 42% carers are eligible for a Statutory Carers' Needs Assessor and referred onto the local authority or their subsidiary for the Borough
- <150 local carers have attended the collaborative partnership 'Carers' One Stop Shop'. 90% intended to take proactive steps to seek support for their caring role





**Do you help someone that needs you?
We're here to support you.**

#THINK CARER

First Thursday of the Month
11:00-12:30
United Reformed Church
New Malden, KT3 6DR

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Q&A



THANK YOU

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