NICE National Institute for Health and Care Excellence

Putting NICE guidelines into practice

Improving how community and hospital-based staff work together to ensure coordinated, person-centred support

Implementing NICE's guideline on transition between inpatient hospital settings and community or care home settings for adults with social care needs (NG27)

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1. Introduction

> "We think that if we could just get the process right it will be fine ... but if we're not all working together towards a common aim, it won't. We need a common understanding of the challenges" (Executive Director of Nursing).

In December 2015 NICE published a guideline on transition between inpatient hospital settings and community or care home settings for adults with social care needs. Findings from two local workshop events demonstrate how the guideline can be used to improve practice. The hosts for these events were Derbyshire County Council and Torbay and South Devon NHS Foundation Trust. Planned and arranged with colleagues from the NICE Collaborating Centre for Social Care, these events provided an opportunity for local managers and practitioners in health, social care and across the wider system to:

- review current practice against the guideline
- identify, and bring together what is working well in practice for shared learning
- identify priorities for improvement
- agree local actions.

Each event had a diverse range of participants, bringing a mix of perspectives from practice and from people who use services. NICE guideline committee members – including an expert by experience - were involved in design and delivery of events. Contributions from the views of local people who use services and carers ensured a strong person-centred perspective. Participants used the guideline to assess how well adults with social care needs in their areas are supported as they transfer from their home to hospital and back again.

This report aims to:

- summarise issues and actions emerging from discussions at both events;
- set out some practical initiatives, ideas and resources identified by participants as examples of what's working well or might help things improve.

2. About the guideline

The guideline aims to improve people's experience of hospital admission and discharge by improving coordination of health and social care services. Its main audiences include health and social care practitioners and providers and commissioners and service users and their carers (including people who purchase their own care). The guideline includes recommendations on

- *Person-centred care* and *communication and information-sharing* –
- *Before admission to hospital*
- *Admission to hospital*
- *During hospital stay*
- *Discharge from hospital*
- *Supporting infrastructure*

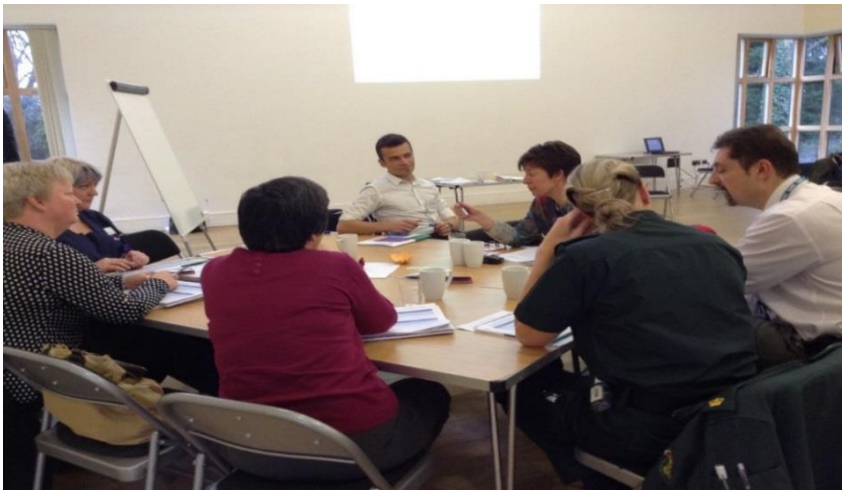
The guideline section Implementation: getting started identifies 3 areas as being potentially challenging to implement. The guideline committee and stakeholders responding to consultation identified one of these – *Changing how community and hospital –based staff work together to ensure coordinated, person-centred support* - as potentially being the most difficult challenge to overcome. Therefore, this challenge area provided the focus for planning and arranging these events.

3. Summary of findings from workshops

3.1 Reviewing current practice against the guideline

> "People can forget to examine what's working, and often a simple thing can make a big difference." (Guideline committee member)

Participants at both events were keen to explore two key questions – *what's happening locally? How can we do things differently to help each other make transfers smooth for people?*



"There's a lot being done locally, people are working hard, and this is a real opportunity to get different perspectives." (Assistant Director, Local Authority)

Setting the scene for more detailed discussions, practitioner representatives from both sites emphasised that much had been achieved and performance against key targets was satisfactory. Each recognised particular local issues and challenges and welcomed the workshop as an opportunity to identify and build on existing local good practice and to give participants the opportunity to learn from each other.

'No matter how good a process is, people are 'emotionally messy' [when they are in hospital] and professionals should be aware of this and what it feels like for people' (Healthwatch Torbay)

Representatives from voluntary organisations shared the views of local people using services. Participants considered how stressful moving into and out of hospital can be and the barriers people can face. A Torbay Healthwatch representative noted that local experience can sometimes reflect descriptions in the Healthwatch England report- Safely home: what happens when people leave hospital and care settings. She also highlighted how use of language and terminology by practitioners, such as the term 'step-down', can mystify, rather than reassure people if they don't understand its meaning.

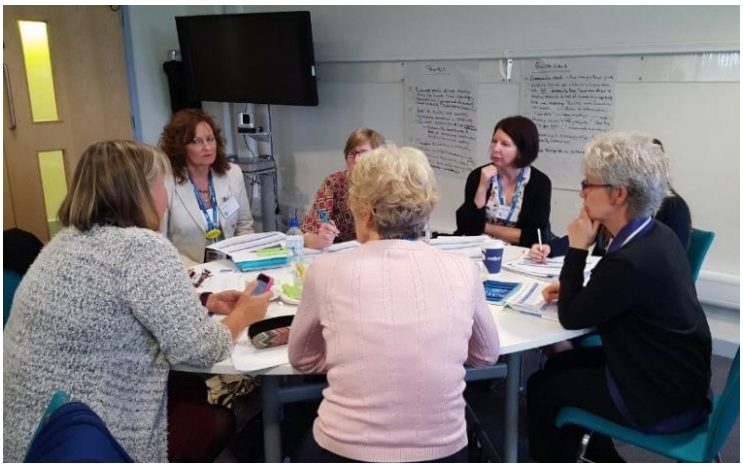
> “One man told Age UK staff, ‘When I hear the term ‘bed blocker, I feel like a blob of tomato ketchup, and someone’s banging on the bottom of the bottle.’” (Chief Executive, Age UK Derbyshire)

Age UK Derbyshire shared other examples of how information can be difficult to understand, particularly when people are confused or upset. People deemed clinically fit to leave hospital may have been exhausted by tests and new medication may not be properly explained. Carers may feel under pressure to take on new responsibilities, only to feel they have failed if readmission is required. Participants agreed that older people need to feel they have a say in discharge plans and that these are discussed with them but that this is not always their experience. Several thought that encouraging use of ‘This Is Me’, the tool from the Alzheimer’s Society, can help ensure the person’s needs, preferences, and interests are taken into account from the outset.

> . “We’re obsessed by complexity and we forget to do the simple things, like talking to someone.” (Group Manager)

3.2 What’s working well in practice locally in the Torbay and Derbyshire areas and why

Building upon these contributions and following some further scene setting to think about barriers and enablers to person-centred integrated working, participants discussed their local practice in mixed community and hospital based groups.



Below is a selection of examples from practice of what is working well around transitions which they identified.

Pre-admission and admission

Practice examples: Being prepared

Age UK's winter wrapped up resource can be used to ensure better information is available about a person on admission by encouraging them to plan in advance away from a crisis. Other examples that can help this include the Alzheimer's Society's This is me**,** used in part, though not systematically, by both systems and initiatives such as the red bag scheme promoted through the Sutton Vanguard and used in some local care homes

Practice example: Information sharing and partnership working

A care home managers and matrons forum**,** led by Torbay's business support and quality team, is bringing practitioners together to enable information sharing and encourage partnership working. The forum has good links with the Care Quality Commission and local care home providers and participants feel that it is helping to prevent unnecessary hospital admissions. The local multi-provider forum also provides an opportunity to share information across the sector.

Practice example: 'Bridge workers'

Voluntary and community sector organisations can help with continuity between hospital and home. Totnes Caring and Dartmouth caring provide 'bridge workers' to help share information. They are part of the multidisciplinary team and have helped to prevent unnecessary admission through community virtual wards as well as to support discharge.

During stay and planning for discharge

Practice Example: Frailty unit, Royal Chesterfield Hospital

The Frailty Unit was set up in June 2014. The aim is to transfer patients to the frailty unit within 4 hours of admission to hospital. They then have an early review by a senior geriatrician and a comprehensive geriatric assessment from the ward's multidisciplinary team. An expected date of discharge is set on admission to the unit. The unit has been piloting an approach to 'discharge to assess' which is showing promising results.

Practice example: SBAR-P (Situation Background Assessment Recommendations People) tool

This tool has been used in Torbay to communicate critical information between practitioners. They have also been piloting an early discharge initiative – 'home before lunch ambition' as described in the NHSE quick guide on improving hospital discharge into the care sector.

Practice examples: Collaborative working across sectors

Both sites highlighted examples of positive collaborative working across health and social care which had resulted in changes to practice. In Torbay nurses described their learning from social care colleagues on risk enablement. In Derbyshire, multi-disciplinary work is developing across the continuum of care and moving away from a sole focus on Delayed Transfers of Care. Emphasis is on communication and trust as the locality moves towards a **trusted assessor model** (where one person or team is appointed to undertake health and social care assessments on behalf of multiple teams, using agreed criteria and protocols) also described in the NHSE quick guide.

Discharge and post-discharge

Practice example: Personalised care and support

Practitioners in Torbay felt much progress had been made in promoting enablement and a strengths based approach, as set out in the Care Act 2014. They also thought that local application of the Mental Capacity Act was working well- though recognised this is always an area for continuous development.

Practice Example: Derventio Housing

Derventio Housing supports people who have recent experience of homelessness and is a registered provider of social housing. The *Healthy Futures* project acts as a bridge between hospital and home for people who have multiple and complex needs, cutting across homelessness, mental health, and drug and alcohol issues.

Practice example: 'One GP'

In Derbyshire, the 'one care home: one GP practice' model was highlighted as improving relationships between care homes and primary care to improve. In some cases, such as at Whittington Moor Surgery in Chesterfield, initiatives such as a telehealth system giving immediate access to clinical support, was enabling better communication to facilitate discharge and prevent unnecessary admission.

3.3 What could be improved and how

Participants identified local areas for improvement and discussed ideas for how they might progress these. Many of the examples of actions and ideas could be applicable and useful for a range of organisations and settings:

Pre-admission and admission

Area for improvement	*How*
Better understanding of the system and how it works	• Promote use of an existing leaflet and local Directory of Resources • Better dissemination of this information, especially via GP practices • Consider extending online resources such as Derbyshire's vSPA to direct public use
Ensuring plans are made with people before they reach crisis	• Bring together population level knowledge of people at risk of admission • Work with voluntary sector to help increase community capacity • Encourage strengths-based advance planning and production of one page profiles or passports. • Promote use of care diaries
Health promotion to manage expectations and encourage self-care	• Use public health and prevention strategies to help people to take greater ownership of their own health – starting with younger people. • Encourage clinicians to focus on enabling people to maintain routine
Better communication between practitioners	• Shared learning opportunities e.g. working with care homes and home care staff to promote training on delirium, dementia etc. • Establish regular forum to facilitate working together

During stay and discharge planning

Area for improvement	*How*
Shared understanding of 'person-centred care'	• Arrange further opportunities for practitioners to discuss this together and with people who use services and carers and representative bodies. • Identify aspects of practice where focused training may be needed • Draw upon local qualitative data to inform work together on national / local targets.
Person/ patient and carer engagement and experience	• Use experience of where decision support tools work well with people to explore whether engagement with people who

	have poor mental health, learning disability or other complex needs could be improved. • Draw upon successful practice in engaging with homeless people. • Explore how discharge coordinators could be more involved as a point of contact for carers.
More common ownership of discharge planning and process to improve continuity	• Apply whole system approach, involving care homes and home care providers as well other community and hospital based practitioners. • Follow – up plan to address culture shift required towards seeing the individual as person we are all supporting – not 'your service user' or my patient.

Discharge and post-discharge

Area for improvement	*How*
Improve administration and information sharing around medication on discharge.	• Adhere to NICE Medicines Management guidelines, and working with pharmacies • Communicate the date of discharge earlier, more consistently, and in a more coordinated manner. • Re-start strategic group to review medication management, bringing together data to understand where action is most needed
Workforce capacity, especially care workers. This issue can be compounded for rural areas or where there are diverse needs.	• Improve understanding of hospital based practitioners about community capacity and what level of support may be needed post discharge. • Consider how training can be better aligned; and to develop a shared understanding of risk. Housing and social care providers could benefit from access to NHS and social care training.
Information sharing and communication on and about discharge	• Communicate expected date of discharge to all as soon as known. • People to hold their own records – with support required for people who may lack capacity. • Use of one page profiles and passports at this point give people the opportunity to update and say 'This is me – now'. • Improve systems and put things in place to monitor and sustain initiatives beyond project stage.

3.4 Priorities for improvement

The workshops were designed to help local systems identify the priority action required to improve transition between hospital and home for adults with social care needs locally. Table 1 below summarises the strongest messages to emerge from the two areas. Even though the localities are very different in many ways, it is notable how much similarity there is between the emerging themes.

Table 1 Key messages about top priorities for improvement emerging from local events

Derbyshire	Torbay
Increase awareness and promoting use of This is me or a similar tool to help older people share information about themselves and what's important to them	Use 'passports' such as This is me as a way of communicating information about people
Improve medication management and information sharing about medication on discharge	Plan medications in advance so they are ready at discharge; communicate about them to people and their carers
Improve information sharing between practitioners, particularly communication between hospitals and care homes, and use of read-only databases	Improve communication between practitioners, people and carers when planning discharge
Communicate the date of discharge earlier, more consistently and in a more coordinated manner	Improve transfer of patient information between hospital and community (and vice versa) to help reduce duplication, be more accurate and ensure available more quickly (Electronic data-sharing).
Ensure plans are made with people before they enter crisis	Encourage people to take greater and earlier ownership of their health and care
Further develop approach to 'discharge to assess and manage', applying principle that people recover better out of hospital	• Get people home earlier in the day – 'home before lunch'- with early coordination of meds, transport, ward round • Ensure that services are in place for people to be supported if discharged at evenings and weekend
Encourage risk enablement as part of discussion about what level of support is 'safe enough' on discharge	Tackle risk aversion by continued focus on risk enablement and self-care

3.5 Action Planning

> "There isn't a single thing [we've identified as good practice] that isn't happening somewhere in Derbyshire. But it is not consistent." (GP)

Reflections on next steps started to generate a number of further ideas:

- get people to think early about 'passport information' rather than when they may lack capacity or are in crisis, for example in GP drop in sessions, through organ donation or using 'soap storylines to reinforce messages;
- think about who else to engage and build ownership across the system;
- extend the offer of existing training opportunities, relevant to this and other NICE guidelines to people locally, including to care workers and family carers;
- explore how initiatives and individual pockets of good practice can be replicated, systematically embedded and sustained.

By the end of the day participants in each event had identified key priorities for action within their health and care system and agreed to contribute to local improvement planning. Each participant also committed to smaller individual actions that they could take forward from the workshop to improve the experience of and outcomes for local people.

> "Hospital admission is a huge deal for older people. Then add dementia, confusion, or sensory loss to that. Little things you do can make a big difference." (Chief Executive, Age UK Derbyshire)

It is for each host organisation to determine how they will use findings from the events. So far, one locality used the event and its findings to inform wider Better Care Fund planning while the other has used the guideline more as a means to check progress against and alignment with existing plans. Both sites are enthusiastic about the benefits of working collaboratively and using the guideline to continuously improve the service they provide to local people with social care needs in transition between hospital and their home.

Acknowledgements

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About this tool

This report is designed to help improve sector understanding of NICE's role in social care and to encourage collaborative working to improve the lives of people admitted to and discharged from hospital. It accompanies the NICE guideline on Transition between inpatient hospital settings and community or care home settings for adults with social care needs (NG27)

It is not NICE guidance.

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Promoting equality

Implementation of the guideline is the responsibility of local commissioners and/or providers. Commissioners and providers are reminded that it is their responsibility to implement the guideline, in their local context, in light of their duties to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations. Nothing in the guideline should be interpreted in a way which would be inconsistent with compliance with those duties.

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