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Carers Support Centre

Review of support for Carers in Hospital and Discharge Planning

This paper provides a summary of ongoing issues that carers in Bristol and South Gloucestershire have raised with Carers Support Centre (CSC) around their experiences of hospital admission and discharge planning.

This report also includes recommendations to ensure that carers are recognised and supported through hospital discharge planning processes going forward.

Summary of ongoing issues affecting carers around hospital discharge

- Hospital discharge often happens before a community care assessment has been carried out and the necessary support and equipment are not in place. This puts an additional burden on the carer and increases the possibility of the caring situation breaking down and potential readmission to hospital.
- Hospital discharge is often rushed, or is earlier than expected and as a result the carer is not ready to support the person being discharged as they had not expected this [discharge] to happen so soon.
- Self-funders caring for people at Southmead can be disadvantaged too as they have to source community care themselves and are not automatically being signposted to home care providers if they are at NBT. This can be overwhelming for carers, many of whom don't know where to start. At UHB, we

understand that there is a specific Clinical Commissioning Group funded post to support people with this.

- Carers are not recognised as ‘expert partners in care’, and often report that they ‘feel in the way’ or ‘ignored’. Carers are ‘experts’ in how the condition impacts on the cared for person and should be valued and respected. The Carers Charter specifically mentions that carers should be treated as ‘equal partners’ in the discharge planning process.
- Long waits for community care assessments after hospital discharge.
- Care packages after hospital discharge are frequently reported as unsuitable, or there are issues around the funding/sourcing of them.
- Carers required to go back to the hospital to collect medication the day of discharge, or the next day. This is extremely difficult for some carers, especially those who use public transport and need to be supporting the person who has just come out of hospital.
- Paperwork does not always get updated during hospital stay to explain any changes in the carers’ circumstances which might make it harder to support the person being cared for.
- People are asked if they are carers when they are admitted to hospital for their own health issues, but this is not always followed up on. E.g. finding out if the carer needs support to get replacement care put in place for the cared-for person. There is variable knowledge amongst hospital staff including paramedics around the CSC Carers Emergency Card.
- Some older carers also have childcare responsibilities for their grandchildren – this is not considered by hospital trusts and carers are expected to give up this duty to care for the person they are caring for on their return from hospital.
- Poorly coordinated discharge for people who have had an admission to hospital due to a fall. CSC recently supported a carer who had been discharged too early and community support was not in place. The carer was unable to cope resulting in another fall and costly re-admission. Better joined up work between hospital and community Occupational Therapists would help with this.
- There is a need for more provision and greater awareness of Extra Care housing options amongst hospital and community

practitioners and how to apply for this. Extra Care housing could be more appropriate in some situations than Care Home provision.

Lack of Home Care Provision

Carers needing a break and/or support with home care after discharge are finding it increasingly difficult to find home care provision. This includes self-funding carers.

It is difficult for carers to arrange both out of hours and day-time visits.

Carers in some geographical areas within Bristol and South Gloucestershire find it harder to access home care provision than others. For example, our work with carers indicates that there appears to be less provision in the Yate, Redland and Clifton areas.

Case Study 1

A South Gloucestershire carer (based in Yate) contacted CSC's CarersLine (telephone advice and information service) and was referred to our Hospital Liaison Team. Her husband had been admitted five months previously to Southmead with kidney failure (she had been told four years ago that he would live for a further two years with dialysis treatment). Initially the social work assessment was that he would need four visits a day from two care workers on each visit. As Social Services struggled to find this package of care, the family agreed to backfill one and then two of the visits so that the patient could come home sooner. They were informed that the difficulty in finding a package of care was due to recent changes within South Gloucestershire whereby care companies were allocated a specific cluster (i.e. specific area) and one care agency had been unable to meet the demand in a particular cluster.

The local authority still struggled to find an appropriate package of care for two visits a day (with two paid care workers on each visit) and the family were told by the hospital that the patient had to move to a residential home, despite the fact that neither he nor his family wanted

this. The hospital said this was due to pressure on beds. This was a very stressful situation for the family.

The local authority eventually arranged for two daily care visits to be provided (with two paid care workers) by the Rapid Response team so that the patient could come home. Four weeks later care is still being provided by the Rapid Response team and Social Services are trying to source three times a day package.

Interim Beds

Interim beds across both hospital trusts have limited capacity to meet the needs of patients who have dementia with specific behavioural needs, as their needs are seen as too complex.

Case Study 2

A patient was discharged from Southmead hospital into interim care – a home for people with varying levels of cognitive impairment. The family felt this was inappropriate as she has no cognitive impairment but agreed to as an interim placement.

The cared for person was in the home whilst the social work team sourced a package of care that had been agreed prior to the hospital discharge, however as time went on there had been no contact with the carer or other family members so they contacted the social work team. They were informed that they had yet to source a care package as there had been a `transfer of funds` which meant that funding responsibility had been moved from the hospital to the community. They were told that once 28 days had elapsed the carer / family were responsible for the care home fees.

After the involvement of various agencies and support advocacy a package was sourced, and support provided, however it highlights the issues around ensuring that discharge is planned, agreed in partnership and communication is effective.

Long Waits for Care Provision

Our hospital liaison team have seen an increasing difficulty in accessing care provision over the past three years (since 2015). Carers tell us that they feel under increasing pressure to backfill parts of a package of care, in order for the person they look after to be discharged from hospital.

Discharge to Assess

Bristol City Council (BCC) has recently introduced a new Discharge to Assess procedure in conjunction with the Community Discharge Coordination Centre (CDCC Bristol Health Partners). This requires ward staff to complete a Single Referral Form (SRF). In order for this form to be completed accurately, ward staff need to have a clear understanding of all the issues including the carer's role and what level of care they are willing / able to provide. Accurate completion of this form is required in order to ensure the patient is directed to the appropriate agency i.e. Community Discharge Coordination Centre or Social Services for support around discharge. Therefore, carer awareness training should be an essential requirement for all staff completing these forms. This training should include how to support carers to have an input into the single referral forms where appropriate.

CDCC has stated that sometimes the SRF does not contain accurate information about a home situation. Sometimes CDCC staff establish following a home visit that more care is required and that CDCC staff have to resolve the situation.

GPs are unlikely to be involved as they have not seen the patient recently.

In addition, due to proposed changes in the discharge to assess process within Bristol, it is likely in the future that there will be fewer social workers on site at UHB and NBT hospitals. This seems to be a retrograde step given the move towards more integrated work across health and social care and this has been identified as a contributor to the difficulties in accessing assessments for the cared-for person.

Reablement Service

Many carers seem unaware of this service. Previously reablement was available for six weeks, but now when it is provided it is only up until the point that a patient has met their rehabilitation goals. This can be less than the six- week period.

Barriers to Accessing Residential Care

Residential care costs are higher than the national average in the South West. The Which Report 2016-7 stated that the national average for residential care was £600 per week and £841 per week for nursing care. The South West average is £655 and £927. In Bristol, the average for residential care is over £900 per week. Bristol City Council has set a Bristol rate of £692 per week for residential homes and £706 for nursing homes. Bristol is in the top five of the most expensive places in country for residential home costs.

We have heard from carers who have to get two or three buses to visit the person that they are caring for in residential care, and so the provision of more residential care placements at the time of hospital discharge is vital.

Carers have reported to us that hospital staff on some wards are not aware of the process for applying for fast track continuing healthcare funding. Further training is needed for staff on this.

Key Recommendations

- Keep social work staff based within hospitals. This enables improved communication across health and social care and smoother hospital discharge. This is especially important during family crisis in complex situations.
- Better employment opportunities for home care staff including training incentives and employment pathways to increase home care provision.
- Clear information for carers and patients on reablement.

- Need for step down bed from hospital e.g. somewhere patients can recuperate following an admission.
- Wider choice of lower cost, good quality residential care.
- More provision of home care.
- Increased provision of intermediate care to enable people more time to ensure their care packages are in place before returning home, or more time for carers, families and patients to make decisions on residential care.
- Improved and more joined-up discharge for people who have had an admission to hospital due to a fall.
- Greater awareness of and more provision of Extra Care housing options among hospital staff.
- Ongoing carer awareness training for hospital staff.
- Support and signposting to self-funded carers to home care options.

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