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Hospital discharge and preventing unnecessary hospital admissions (COVID-19)

18 January 2022

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About SCIE

The Social Care Institute for Excellence improves the lives of people of all ages by co-producing, sharing, and supporting the use of the best available knowledge and evidence about what works in practice. We are a leading improvement support agency and an independent charity working with organisations that support adults, families and children across the UK. We also work closely with related services such as health care and housing.

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- identifying and sharing knowledge about what works and what's new
- supporting people who plan, commission, deliver and use services to put that knowledge into practice
- informing, influencing and inspiring the direction of future practice and policy.

First published in Great Britain 2020, updated January 2022 by the Social Care Institute for Excellence

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Introduction

This guide discusses the lessons learned from hospital discharge and avoidance during the COVID-19 pandemic. It highlights challenges faced and good practice to prevent unnecessary stays and admissions going forward.

From March 2020 there was urgent pressure to free up 30,000 (National Audit Office, 2021) NHS beds to cope with COVID-19 admissions. Hospitals, in effect, closed to all but urgent and emergency care. The **government guidance** applicable at that time directed rapid discharge of everyone clinically ready. It required transfer off wards within one hour of a discharge decision to a designated discharge area, and then discharge from hospital as soon as possible, normally within two hours.

Councils responded rapidly to deploy resources and work with NHS colleagues to establish and enhance discharge routes. For commissioners, this was crisis market shaping at pace to meet the demand. Whilst there was much emphasis on expanding existing capacity through care homes and home care, there was also community innovation that enabled choice and flexibility through, for example, direct payments, Shared Lives, micro-enterprises and targeted step-down support.

Evidence shows that it is better for people, and more cost-effective, where clinically appropriate, to spend a short a time as possible in hospital, and to avoid going in to hospital when healthcare can be delivered safely in the home environment. (Analysis by Age UK shows that the average excess bed day – the cost of a patient remaining in a hospital bed after their treatment has ended – costs £346.) The discharge to assess model has been effective at reducing stays and supporting timely discharge. NHS England and NHS Improvement (NHSEI) reported a 28% reduction in patients staying over 21 days in hospital between winter 2020/21 and winter 2021/22. The model aligns with the strategic direction to deliver more care within and closer to home. This must though be set in the context of choice as well as sustainable support that builds confidence and makes a positive difference to people and their networks.

Tragically, the care sector has been at the centre of the UK COVID-19 outbreak. We must learn from this to address immediate concerns with citizens, carers, workers and providers, not least because we continue to experience high infection rates, new variants and severe winter pressures. Councils face growing financial pressure as Government emergency funding has not been sufficient to cover lost income plus the cost of their COVID-19 response. Discharge funding has been reduced from six to four weeks and will end on 31 March 2022 adding further challenges to local authority budgets. The NHS Confederation fear this will lead to a damaging ‘cliff edge’ of increased length of stay, delayed discharges, pressures on resources and avoidable readmissions from April 2022. It has set out **the case for permanent funding** to support the ‘discharge to assess’ model and sustain progress.

The NHS is also under considerable stress as high COVID-19 rates impact on patient care, staff absences and the resource demands of delivering ongoing vaccination and booster programmes. This compounds existing workforce pressures with Brexit, vaccination requirements and labour shortages in other sectors making it harder to attract and retain health and care workers.

Longer-term budgets and strategic planning are essential to ensure learning underpins action to address the disproportionate impacts of COVID-19, particularly on older and Disabled people, and deliver real choices for people to stay out of hospital unless absolutely necessary. The aim must be to do more of what works well, that helps people be connected in their own communities with responsive support as needed, ultimately supporting better outcomes. This planning must be informed by the experiences of people who draw on support and their networks about what works as well as the views of workers on the ground to ensure future approaches are joined up and effective.

Commissioning lessons

Rapid hospital discharge and avoidance, especially in the early months of the pandemic, resulted in deaths, trauma, limits to people's freedom and choices, and many people not getting support that is right for them. The **other guides in this series** set out the devastating impacts of COVID-19, particularly on older and Disabled people, people from Black, Asian and minority ethnic (BAME) communities and on care workers. Commissioners must help ensure all people now get the choice of support that makes a positive impact.

Commissioners should be asking:

- What has stopped people going home or to a place of their choice?
- What has stopped people moving on from care homes if that was meant to be a temporary arrangement?
- Why haven't people been able to cope at home? What would have helped?
- What has worked well that we want to build on?

There are some common features where discharge and preventing unnecessary hospital admissions has worked well, and these core principles should become the cornerstone of a positive commissioning approach:

- **Leadership** – strong local decision-making based on good local evidence has saved lives. Good leadership listens to people and creates the conditions to identify solutions.
- **Choice** – people have better outcomes where there is more diverse provision, along with good information and advice so people are empowered to make choices that are right for them. Good holistic support keeps people connected to their networks and communities.
- **Agile and confident** commissioning that develops flexible solutions based on knowing communities and providers well, including local businesses.
- **Co-production** that genuinely shapes decisions and understands the impacts on people who need care and support, and on carers.

- **Communication** and relationships with social care practitioners, support workers, providers and community groups are vital. What issues and barriers are they aware of? What are their ideas for solutions?
- **Integrated and collaborative** working across systems, including with housing partners, using holistic and whole-family approaches, to reduce hand-offs, delays and confusion.

What are the immediate issues to be addressed?

In the early months of the pandemic commissioners were dealing with urgent issues to ensure people with support needs and workers were safe, to secure delivery capacity and support the viability of providers. Significant time has elapsed since the start of the pandemic but it remains vital to understand and address issues that still affect many people following hospital discharge. Commissioners must also ensure that where there have been positive changes and better approaches to reduce hospital stays and preventable admissions, these are embedded and built into ongoing recovery plans. Commissioners need to avoid reconstructing things people don't want. Immediate commissioning tasks include:

- Understand where people have been moved to and who is still not living the way they would wish to. Commit to a clear focus on choices. For people who were discharged to care homes, find out where they want to be and ensure the local capacity, information and advice to support those choices. Ensure there is follow-up and choices for people whose homes may be unsuitable or whose informal caring arrangements may no longer be sustainable.
- Use evidence about the risks – understand local impacts and how to avoid repetition of what didn't go well. This may need particular focus on larger care homes, services that were unable to operate during the pandemic or how specific groups have been affected.
- Avoid hospital re-admission by maximising independence support and health interventions including through timely provision of **reablement** and technology. Consider how existing contracts and local services can support this.
- Address the trauma that people have faced. This might be via mental health and bereavement support for people who use services, carers and workers. This is vital so people get the help they need and, where appropriate, are supported to continue their work roles or to sustain their caring roles (if they wish to). Support needs to reach workers who have since left the field, perhaps as a result of their experiences during the pandemic. Particular attention will need to be paid to reaching hidden carers.
- Improve quality of life – what can be done quickly and safely to improve people's health and wellbeing? This means attention to visiting arrangements, supporting positive relationships, safely restarting activities, supporting digital connections too so people aren't further excluded, and ensuring the availability of advocacy and carer support.
- Stabilise the market, but plan for the long term. Commissioners need to ascertain which services have done well and which could do better with some support. Are there any off the radar such as hospices, services for carers or more innovative community supports?

What is the ongoing role of mutual aid groups and can they be better supported? What are the financial challenges and opportunities?

- Equalities – understand and address the impacts of hospital discharge and prevention across different communities. Data tells an important story but linking directly with communities is vital to understand respective experiences, ideas and to co-design appropriate local solutions.
- Co-production – people must be at the centre in decisions that affect their lives and in designing services and solutions. People need choice and control so support is built around their strengths, own networks of support, and resources (assets) that can be mobilised from the local community. It is important to afford sufficient time to understand people's experience of coming out of or staying out of hospital – their fears, concerns, what worked well, what didn't – so this can properly inform local plans. This will not be just about health and care services, but about wider community support and access.
- Financial planning is vital to ensure innovative and sustainable approaches don't suffer as councils struggle to balance the books and perhaps revert instead to traditional delivery. A focus on enablement, prevention and connections is vital particularly for those who have been discharged from hospital with expensive packages of care, but without the ongoing focus on rebuilding confidence and connections.

Discharge guidance and good practice advice

The discharge to assess model has been implemented since March 2020 to support more people to be discharged to their own home, reduce the length of stay in acute care, improve people's outcomes following a period of rehabilitation and recovery, and to minimise the need for long-term care at the end of a person's rehabilitation.

The **Discharge guidance** sets out a 'discharge home today' policy requiring collaboration and joint working between providers and commissioners to deliver operational coordination and ensure provider capacity. There are four pathways, each with anticipated percentage uptake, with community health services taking the lead for people needing any level of support under the **discharge to assess model** (D2A):

Pathway 0: 50% of people: simple discharge, no input from health/social care.

Pathway 1: 45% of people: support to recover at home; able to return home with support from health and/or social care.

Pathway 2: 4% of people: rehabilitation or short-term care in a bed-based setting.

Pathway 3: 1% of people require ongoing 24-hour nursing care, often in a bedded setting; long-term care is likely to be required.

There are three stages to the discharge to access model:

Stage 1 – Review each individual daily and identify people for discharge to leave that day

A clinically-led review (or equivalent in a community hospital setting) involving social care colleagues focusing on 'Why not home? Why not today?' for those not needing 24-hour care and 'If not home today, then when?' to set an expected date of discharge.

Stage 2 – Multidisciplinary work to plan discharge

Once the decision has been made to discharge a patient, community health, social care and acute staff work together (including housing professionals where applicable) to ensure that the patient is discharged on time.

Stage 3 – Assessment and care planning at home

Assessment and care planning is then carried out at home. The single coordinator ensures staff and equipment are available to provide for immediate care needs, review and assess for longer-term care packages or end the support if no longer required. This should ideally take place on the same day of discharge. If needed, a care coordinator works with the person in their 'temporary' care home to ensure they can move as soon as possible to their chosen long-term care home or return to their own home.

No one should need to transfer permanently into a care home for the first time following an acute hospital admission. Everyone should be offered the opportunity to recover and rehabilitate at home or in a bedded setting before their long-term needs and options are assessed and agreed. For people whose needs are too great to return to their own home, short-term care and recovery/rehabilitation in a bedded care facility will be arranged through the case manager. Assessment and personalised care and support planning will then happen towards the end of the recovery/rehabilitation period.

A carer's assessment can be completed after discharge, but should be undertaken before caring responsibilities begin if this is a new caring duty or if there are increased care needs.

A financial assessment by the local authority will also be required if ongoing social care is needed.

During the emergency period, the Government funded (via the NHS) post-discharge recovery and support services, rehabilitation and reablement (over and above those in place prior to admission) for up to six weeks. This reduced to four weeks from 1 July 2021. The scheme will end 31 March 2022 and will not fund care delivered after this date.

Making it happen – discharge guidance

The guidance sets out the respective roles and lead responsibilities for implementation and to ensure seven-day-a-week discharge arrangements as summarised below.

- Clinical commissioning groups' (CCGs) commissioners need to work with local authorities to ensure sufficient provision based on home-first discharge to assess principles and that an appropriate market rate is paid for support. This must also ensure appropriate commissioning arrangements for palliative care and support at end of life.
- Section 75 agreements can be used to collate additional funding and commission enhanced supply and provision.

- Staff to be deployed flexibly to coordinate, manage and support the discharge arrangements. Multidisciplinary teams to arrange packages of support and equipment for discharge and follow up patients to assess for long-term needs.
- Delivery of enhanced occupational therapy and physiotherapy to support discharge and recovery.
- Councils and adult social care to coordinate discharge work with voluntary sector organisations.
- Councils to lead the contracting responsibilities to expand capacity in home care, care homes and reablement services paid for from the NHS.
- Community palliative care teams to take responsibility for anyone identified as being in the last days or weeks of life and needing support at home or transfer to a hospice.
- Care providers including hospices should maintain capacity and identify vacancies completing the Capacity Tracker daily.
- Systems partners - CCGs, trusts and ICSs/STPs - to agree and support expected levels of performance and ensure appropriate data collection to inform the best outcomes for individuals and ensure discharge pathways are working effectively. This includes understanding where people have moved on to and why some people remain in hospital.

There were huge concerns early in the pandemic over people being discharged in to care settings without the necessary testing and before care homes had advice about arrangements for isolation. There is now specific guidance regarding **Discharge into care homes for people who have tested positive for COVID-19** (DHSC, 2020) and **Discharge into care homes: designated settings** (December 2020; updated May 2021). This requires hospitals to undertake PCR tests on all people discharged into a care home in the 48 hours prior to discharge.

People who test negative can be discharged to any care home where they should undergo 14 days of isolation as a **precautionary measure**. The outcome of tests should be shared with care homes prior to discharge and be included in the discharge summary information.

Anyone testing positive who would otherwise be returning to the care home from where they were admitted, or for individuals who are unable to go home and being discharged to a care home for the first time should be discharged into a designated setting in the first instance. There are some exceptions such as people who are within 90 days of their initial illness onset and not considered to pose an infection risk.

The guidance requires commissioners to ensure sufficient provision of designated settings (see later) for people to be safely discharged to. These are settings that the Care Quality Commission (CQC) has inspected and assured for infection prevention control (IPC) standards as meeting **CQC's IPC protocol** and as having the ability to zone COVID-19 positive residents with a dedicated workforce and high levels of ventilation. People should undergo a 14-day period of isolation before moving into a care home from a designated setting. The costs of the designated facilities will be met through the £588 million discharge funding.

Good practice advice to improve hospital discharge

Commissioners have an important role in supporting effective systems across health, social care and beyond so people can leave hospital at the right time, to the right place with the right support. This includes governance and market shaping to ensure the capacity and choice of quality provision. It's much better for a person's physical and mental wellbeing to leave hospital as soon as medically 'optimised' for discharge. Every extra day in hospital adds risks of functional decline particularly for older people. Yet, each year, nearly 350,000 patients spend more than three weeks in acute hospitals. The 'Where Best Next?' campaign asks 'Why not home? Why not today?' and promotes early planning and multidisciplinary work to ensure discharge is person-centred, appropriate and timely. This is needed beyond the funding of discharge programme to ensure ongoing focus on outcomes and swift but appropriate discharge.

'**People First, Manage What Matters**' sets out ways to improve patient flow and reduce the numbers of delayed transfers by:

- improving hospital discharge including **discharge to the care sector**
- making better use of care at home
- enhancing health in care homes
- using trusted assessment approaches.

The LGA **High Impact Change Model** for managing transfers of care outlines changes to improve health and wellbeing, minimise unnecessary hospital stays year-round and encourage new interventions. It is underpinned by the **Ethical Framework for Adult Social Care** to support quality outcomes for people based on what matters to them. Key elements of particular interest to commissioners are:

- Early discharge planning with systems to monitor and respond to demand and capacity. It proposes a 'place-based approach' to develop creative solutions which could focus on, for example, health inequalities or risk groups needing targeted support post-COVID-19 infection.
- Home first as the preferred option, rather than by default to bed-based care.
- Discharge to assess (D2A) with a single point of access and multidisciplinary working for holistic approaches and to remove handoffs.
- Engagement and choice. A hospital is not the right environment for people to make long-term decisions about their ongoing care and support needs so assessments should be at home with families, carers or advocates, after reablement or rehabilitation if required.
- Trusted assessment using asset- or strengths-based approaches to build on people's skills, networks and promote their connections and independence.
- The use of effective housing, home adaptations and assistive technology services to enable people to live as independently as possible.
- Improved discharge to care homes when that is the choice.

ADASS & LGA (February, 2021) set out 'top tips' in **Implementing a home first approach to discharge from hospital** which focus on leadership, clear governance and joint-funding

arrangements, pathways, partnership and integration opportunities; collaborative commissioning, workforce, and effective use of data.

Factors affecting people's experience of hospital discharge and admissions prevention

The success of any approaches must also be judged by people's experiences and so commissioners should design in ways to listen to people – how things have gone and what could have worked better.

> "I need more help when I come out of hospital, just temporarily, and this shouldn't be something I need to fight for or organise myself when the doctors have said it is a condition of me going home."
>
> **Social Care Future - Living in the place we call home (Social Care Future)**

It is vital on leaving hospital that people and their networks are empowered and understand what will happen next, especially as discharge can happen at pace. Hospital discharge fact sheets such as those by **Age UK** and **Alzheimer's Society** can help. People also need to understand that care may become chargeable – something that may be an unwelcome surprise to many.

People's living circumstances play a significant role too - do they have friends and neighbours they can call on; do they have digital access? **Red Cross** research in 2019 found examples of people returning to homes inappropriate for their recovery, with no hot water or heating or homes where they struggled to be independent or felt unable to get upstairs to the toilet. It also found that many clinical staff and some social care staff were not aware of other services, often offered by the voluntary and community sector. It recommended that people's non-clinical needs should have parity of esteem with their clinical needs. Improvements should include commissioners and providers harnessing the power of non-clinical support, including the voluntary and community sector; and the development of a discharge 'independence check', much of which should be covered through D2A, which would address:

- Practical independence (for example, suitable home environment and adaptations)
- Social independence (for example, risk of loneliness and social isolation, if they have meaningful connections and support networks)
- Psychological independence (for example, how they are feeling about going home, dealing with stress associated with injury)
- Physical independence (for example, washing, getting dressed, making tea) and mobility (for example, need for a short-term wheelchair loan)
- Financial independence (for example, ability to cope with financial burdens).

Analysis by **NHS England** demonstrated a strong relationship between the rate of emergency admissions and socio-economic deprivation. In areas where the most deprived 10% of the population live, the rate of emergency admissions is more than twice that in areas where the most affluent 10% of the population of England live. It also showed that higher rates of expenditure on social care appear to be associated with lower levels of emergency admissions.

The pressures on availability of home care, due to lack of or churn of workers, as well as a time and task focus, may mean people don't get the right amount or the right type of support to enable them to stay safely at home.

People's access to GPs also impacts on emergency admissions. **The Health Foundation** found lower rates of emergency admissions for people who found it very easy to access their GP surgery on the phone and for people who were always or almost always able to see their preferred GP if they had one.

Challenges in transfers to care homes

Data analysing COVID-19 rates in care homes early in the pandemic found that the likelihood of UK homes being infected with COVID-19 tripled with every additional 20 beds. In homes with fewer than 20 residents, the chance of an outbreak was 5%, but in homes with 60 to 80 residents the likelihood was between 83 and 100%. This trend did not appear to continue into subsequent peaks. The average UK care home has around 36 beds, HC-One, the largest provider of private care homes, averages 50 beds. Care UK, another major chain, averages 66 beds.

The Office for National Statistics found that regular use of temporary 'bank' staff who worked across several homes – a common practice among larger operators – increased the risk of infection more than one and a half times.

NHS England report that 25,060 hospital patients were discharged to care homes between 17 March and 16 April 2020. Routine testing of all discharges only began on 16 April, by which time there were grave concerns about personal protective equipment (PPE) shortages and that older people would be especially at risk. Some local authorities pre-empted the devastating risks of transmission; they quickly closed care homes to all new admissions and began their own testing programmes, such as in **Hammersmith & Fulham**. However, care home discharges (as a percentage of all hospital discharges) across England doubled in late March 2020 from 2% to 4%.

The issues faced in care homes during the first few months of the COVID-19 pandemic include:

- More than **29,000 excess deaths** in care homes up to 12 June 2020 and over 19,000 COVID-19 related deaths from April to end December 2020, and considerable regional variation.
- Over 40% of all care homes **reported an outbreak up to 7 June 2020**.
- Outbreaks were up to **20 times more likely in large care homes**. High footfall including agency workers, cooks, cleaners and maintenance engineers, going in and out of the largest homes is thought to have been a key factor for infecting residents. Non-care staff were less likely to wear PPE and more likely to work across multiple locations **than care workers**.
- Lack of access to whole-home testing for all residents and staff plus early difficulties using the national testing programme added to transmission risks.

- Lack of specialist healthcare going into care homes which resulted in people suffering a range of health complications – not just COVID-19.
- Residents – many of whom have dementia – experienced distress, confined to their rooms with no outside visitors for months on end.
- Poor or rushed assessments following rapid discharge from hospital made it hard for staff to understand the needs of new residents.

Morciano et al (2021) found that during the first 23 weeks (to 7 August 2020) of the pandemic in England excess deaths were higher in nursing (8.4%) than residential (4.6%) homes. Of the excess deaths, 64.7% were confirmed/suspected COVID-19. Almost all excess deaths were recorded in the quarter (27.4%) of homes with any COVID-19 fatalities.

Care homes implemented enhanced infection control measures and ongoing visiting restrictions to protect residents. These continued over the months and into 2021 as the country experienced new waves of COVID-19. Whilst protecting against infection, restrictions on visiting and residents' freedoms has had a hugely detrimental impact on the health and wellbeing of residents and their families. This is not to ignore the amazing ways that many care homes have creatively supported ongoing contact and virtual visits. The **SCIE commissioning guide Understanding the impact of COVID-19 responses on citizens** explores in more detail how COVID-19 and the responses to it have affected residents, families and care workers.

More recent analysis of CQC data in **ONS** reports show 19,248 COVID-19 related deaths in care homes with 11 beds or more from 10 April 2020 to 31 December 2020 and a further 11,257 in 2021 to 26 November 2021.

A **CSI report in July 2021** highlighted data from CQC COVID-19 insights into care home deaths including the following:

- During the first two peak periods of COVID-19, April to September 2020 and October 2020 to March 2021, 39,350 deaths in care homes were attributed to COVID-19.
- The trend of disproportionately higher death rates attributable to COVID-19 in larger homes that was evident in the first peak did not continue into the second, though there was a higher prevalence in homes specialising in dementia, and in nursing homes.
- The estimated 15,356 deaths in care homes attributable to COVID-19 between April and September 2020 accounted for 17% of the nearly 95,000 care home deaths during the same period.
- 56% of care homes in England reported no COVID-19 related deaths in the period.

It is important for commissioners to understand their local data, what is driving particular trends – good or bad – and what that means for people's journey on leaving hospital. For people who do move into a care home, this should be based on choice rather than lack of viable local alternatives. As further waves of COVID-19 continue, commissioners need to focus on developing alternatives as well as coproducing improvements that support care homes to enhance quality of life and enjoyment for residents and their loved ones.

Provider concerns

Care home providers have continued to raise concerns about risks, viability and rising costs. They are concerned about contractual obligations for staffing levels and activities, and also contingency planning and share of risk with commissioners. Two-thirds of providers said they fear for their future. HC-One, the UK's largest care home provider, said occupancy levels fell so sharply during the pandemic that it was no longer generating cash. The UK's second largest provider, Four Seasons Health Care, had already gone into administration in April 2019, though **continued to operate**. This adds worries for individuals and families concerned that provision will collapse or costs, particularly for self-funders, will continue to rise.

The National Care Forum's **top tips** reflect concerns as to whether discharge guidance would be properly followed advising providers to:

- secure sufficient fees to cover additional and specialist costs
- seek guarantees about local community health support
- insist on testing and COVID-19 status
- seek assurance about PPE supplies
- insist that assessments give the right information and clarify what happens if the person's needs cannot be met following a full needs and care assessment
- complete the **capacity tracker** (and nothing else) as the single mechanism for collecting data on COVID cases, bed availability, staffing and PPE pressures.

These concerns need attention but commissioners should not prop up the market at all costs if quality and outcomes cannot be demonstrated. Immediate measures continue to be needed to ensure safe support in care homes and to restore people's freedoms, but many people also need to move on. People need viable alternatives for support in the community to secure their choices and outcomes.

What has helped support hospital discharge and prevent unnecessary admissions?

The examples in this section show a range of approaches and interventions that have supported better outcomes. Some are specific to a particular setting but many could be beneficial with other combinations of support. For example, enhanced health support, connection with family and friends, support for physical and emotional wellbeing will be helpful in any setting. General enablers of good practice include:

- Support that focuses around people's networks of carers, families and friends.
- Community mobilisation with practical support that connects people with local resources.
- Information, advice and time for people to think through the options that are right for them.
- Flexibility, confidence and responsiveness of providers.

- A confident, supported and empowered workforce.
- Communication, trust and positive relationships with providers including data and intelligence sharing.
- Use of technology that enhances rather than replaces human contact.
- Access to health support and advice.
- Agile commissioning, flexibility of contracts that supports the above.

Local authorities have worked hard to stabilise the sector and ensure the availability of provision for hospital discharge. They have provided funding to providers to support cash flow, sustainability, cover excess costs and extend services. Examples of support in relation to hospital discharge and preventing admissions include:

- Increased rates for home care and care homes, contingency funds for direct payments and financial support for unpaid carers.
- Block booking beds to support viability of homes running under capacity to reduce infection risks and securing capacity in infection-free services.
- Supply of PPE.
- Local testing in advance of and to fill gaps in the national programme.
- Funds to support and sustain voluntary and community sector organisations including funding to expand some activity.
- Workforce support to re-deploy and recruit additional staff or volunteers and provision of training.
- Funding crisis accommodation for people with learning disabilities and mental health needs.

Actions that have helped discharge and reduced transmission in care homes

The impact on people in care homes has been devastating, so ensuring safe support is a priority along with enabling alternative choices through other support options. Isolating (in the clinical but not emotional sense) infected care home residents is recognised as essential, but transmission within and across care homes has continued well into the pandemic. It is vital to continue to address this even as the vaccine is rolled out, given the likely subsequent waves and new variants. The following actions have helped deliver safer and quality support:

- ‘Cohorting’ residents or creating ‘bubbles’ has helped minimise transmission and deal with outbreaks without residents always being confined to their rooms. Flexible use of space and care corridors enable staff to avoid crossover of those caring for symptomatic residents.
- Regular testing and re-testing to confirm COVID-19 status and obtaining written confirmation for new referrals. Accepting no new or returning residents unless they can be supported safely.

- In Ealing, the NHS opened a special unit to accept infected care home residents as well as infected hospital patients prior to discharge to homes.
- Minimising outside infection risks to staff by providing transport or car pool so they do not have to use public transport.
- Clear and consistent messages about the use of PPE and training on infection control for care home staff.
- Appropriate medical care to prevent urgent admissions. Examples include video call ward rounds to care homes and follow up calls to relatives; establishing 'virtual' GP and pharmacy appointments for residents via iPads.

Emotional support is vital for people's health and wellbeing. Relatives have also faced anxiety and some care homes have been really creative helping families to stay connected with innovative visits or virtual link ups. Many staff have gone above and beyond: there are examples of workers moving in to minimise risks and to ensure continuity of care.

The work for staff during COVID-19 has often been intensive and isolating. Some providers and councils have provided support such as access to a clinical psychologist, mindfulness and counselling, daily check-ins, more frequent informal supervision, WhatsApp groups and virtual team meetings. Recognising the difficulties is important as is finding things to celebrate and bring enjoyment to people.

> *People feel supported at every level; if we can get through this together we can get through anything.*
>
> **Portsmouth**

Use of hotels and building based resources

There are examples of step-down facilities being quickly mobilised and staffed by councils, CCGs and nurses to support people who no longer need to be in hospital.

Buckinghamshire Council made up to 240 beds available as a care and reablement centre within just three weeks, staffed by care workers and a team of volunteers. This supports people leaving hospital but unable to return home, as well as those who live at home but who may need temporary short-term support.

Reading Borough Council paid for use of **hotel rooms** at a local Holiday Inn. This operated as a 'discharge to assess' facility, allowing time to arrange care packages and equipment for people due to go home. Others stayed in the hotel to protect shielding relatives, or self-isolated with COVID-19 symptoms.

Hammersmith & Fulham made similar arrangements with Novotel but these were stood down when capacity was not needed. Astute commissioning enabled good ongoing relationships with the business whilst avoiding expensive contractual commitments.

UK hotels offer respite to non-COVID patients (The Guardian)

Rapid discharge and enablement pathways

Many areas built on existing home-first work (D2A), and enablement approaches to tailor support and provide a 'safety net' for the person. Some areas moved occupational therapists (OTs) to frontline calls to provide or advise on reablement, home equipment and adaptations

so people did not lose skills and independence. Other examples that commissioners may want to build on as ongoing approaches are set out below.

The Reactive Emergency Assessment Community Team (REACT) focuses on preventing avoidable admissions in Ipswich and East Suffolk. The integrated team provides a medical crisis response, care home initiative, reablement, specialist dementia support and emergency department front door therapy services.

Accelerated by the crisis, the model was enhanced and integrated with locality Integrated Neighbourhood Teams (INTs). A discharge hub operates seven days per week, and nursing and therapy capacity has shifted from acute to community. Central REACT clinical triage coordinates a localised response from neighbourhood teams within two hours for stable crisis referrals and a specialised response for complex crisis referrals with local team follow-up once stabilised. This has resulted in better patient outcomes, smoother pathways, care closer to home, reduced hospital stays (and associated decline), and lower overall costs.

Portsmouth worked on **improving flow** by accelerating their home first approach. Hospital social work staff were deployed into the community to assess people within 24 hours of discharge. A central hub deals with step-up and step-down referrals with 'hotlines' for hospital and community in-reach teams. Length of stay has reduced from four or five days to less than one day.

In Somerset a comprehensive systems approach links hospital discharge and avoidance with **Community Connect** to maximise local support and connections. Outcomes through rapid response are enhanced by a locality neighbourhood approach and innovative micro-providers delivering a wide range of flexible support.

Developing a capacity and demand model for out of hospital care: learning from supporting seven health and care systems (LGA, 2021) also provides examples and shares the learning from developments that took place in seven health and care communities between July 2020 and June 2021. Whilst there were challenges in bringing together health and social care data to understand the demand and pressures on commissioned services, it demonstrated that the better-staffed community hospitals can help get more older people back to their own homes; and support for care homes by therapists and nurses can also increase the percentage of older people then returning home. Each system was concerned about the availability and supply of domiciliary care and in several places, workshops were organised to explore this and inform local action plans.

Community mobilisation, micro-enterprise and practical support

The amazing community mobilisation across the country has supported people with food, delivery of medicines and PPE, and kept people connected with phone calls. This practical support and community connectivity provide confidence and reassurance that makes the difference for someone to feel OK being at home.

Somerset **Community Connect** demonstrated how strong community partnerships helped the response to the pandemic. Building on their existing platforms, they adopted a strengths-based and community-led approach to supporting those at risk during the crisis. People shielding are contacted by village agents, social prescribers and district officers. Alongside the voluntary community and social enterprise (VCSE), they coordinate practical support and

supplies – 1,300 volunteers are signed up as corona-virus helpers. People are linked with community groups such as neighbours helping neighbours and numerous activities including the 16 talking cafes that are continuing online. Support is truly local and personalised with 575 micro-providers supporting 2,300 people with a range of needs each week.

Practice example: **Somerset Community Connect**

Enhanced health support and testing across all community options

Enhanced health support and access to testing has helped limit transmission, prevented people going into hospital unnecessarily and enabled people to be discharged safely from hospital. Examples include:

- A local seven-day public health support and advice line on COVID-19 for care providers.
- Expert training and advice, e.g. weekly webinar training session on infection prevention and control for providers.
- Early and easy-to-access arrangements for testing and, importantly, re-testing for people in **all** care and support facilities (e.g. Bexley with Queen Elizabeth Hospital pathology lab).
- Sheltered housing and learning disability homes were set up with a SATs monitor and video consulting.
- Ambulance services providing expert clinical triage for people at home.
- The Hillingdon Hospital set up a neuro outreach service for patients who were discharged early from a neuro rehabilitation unit, or would have been referred to an inpatient neuro rehabilitation service.
- Royal Berkshire Hospital adopted an Italian triage pathway for patients with breathing difficulties. Those able to return home are given a pulse oximeter to monitor their oxygen levels and clinicians track patients by phone.
- Tower Hamlets GP Care Group and Bikeworks provide COVID-19 home monitoring kits including a pulse oximeter, thermometer and blood pressure monitor.

Support by unpaid carers

Most people discharged from hospital go home and are supported by family, friends or neighbours. There are an estimated 4.5 million extra carers as a result of COVID-19, and most existing carers are providing considerably more care. The right help and advice for carers is essential to support this. Commissioners should seek feedback from carers, carers organisations and from carers assessments to understand the needs. Community and health support with access to rapid support when needed must be available to carers.

- **Coming out of hospital** describes what can help. What makes caring sustainable is often a range of practical support, combinations of paid support, **short breaks**, emergency back up and advice rather than an all or nothing input.
- Practical support quickly in place is vital e.g. PPE, food, the right equipment and healthcare. Peer and emotional support is important as many carers feel isolated and abandoned. Carers often face a huge financial hit so advice about employment, finances and benefits is essential for carers supporting loved ones out of hospital.

- Support for the use of direct payments including to pay carers for the additional support they have taken on has enabled some people to get the support they need whilst shielding and settling home after hospital.
- Young adult carers may be facing additional pressures during lockdown. These co-produced **top tips**, whilst aimed at education staff, provide great advice on supporting and identifying young carers.

Direct payments

Direct payments (DPs) offer choice and control enabling people to put in place support that is right for them. This can be ideal for hospital discharge and flexible support to prevent unnecessary hospital admissions. Examples of recent use include:

- Targeted information to discharge teams about DPs and early information to explain to people who are leaving hospital how DPs could be used.
- Support and reassurance to use DPs flexibly to continue to meet needs during changing circumstances.
- Advice on employing family and household members when other support isn't appropriate due to transmission risks, including for hospital step down.

Hospices

Hospices frequently demonstrate good practice with compassionate and whole-family approaches. In relation to hospital discharge, the following examples are of note where a hospice:

- increased inpatient unit bed capacity by 10 beds to support rapid discharge of end-of-life patients
- repurposed its wellbeing centre therapy rooms providing extra inpatient rooms
- re-organised its community team to provide a 24-hour rapid response team in the community linking closely with NHS neighbourhood teams.

Community support

Commissioners in many areas secured extra capacity with homecare providers to ensure ongoing support where needed for people discharged from hospital or for people not able to access regular activities. In addition, diverse person-centred flexible support, including that from locally based community-focused organisations or user-led orgnisations helps to achieve good outcomes and respond to people's changing circumstances:

- Self-managing teams e.g. **Wellbeing Teams** are by definition flexible and responsive coordinating support around people's networks. These approaches work well for hospital discharge and can also enhance input when people would otherwise face a bed-based admission.
- Individual service funds (ISFs) are similarly flexible as providers (e.g. **Yarrow**) can flex support quickly in line with people's needs and preferences and make really good community connections.

Shared Lives

Shared Lives offers high quality support for people with a range of needs and is strongly placed to respond rapidly to add local capacity (**Growing Shared Lives**) including for hospital discharge, such as that offered by **PSS home from hospital**.

> *'Lots of evidence of how it works really well for hospital discharge and back to independence but also builds relationships and connection that is sustained even when people move back home. Lots of schemes taking referrals, fast tracking new carers assessments, using tech to make matches, etc. Now that testing is more widely available, it should make things easier, too. We want to scale this solution up in response to the crisis.'*
>
> **Shared Lives Plus**

Shared Lives schemes are already successfully supporting people with a range of health needs, including mental ill-health and acquired brain injury. The **Shared Lives in Health report** demonstrates potential to use health budgets to effectively support more people with a range of health needs and scale Shared Lives accordingly.

> *'Shared Lives can support reablement and provide a safe, family environment that offers professional, regulated care. In the current climate this is especially relevant when we consider the increased pressure on our health services during COVID-19.'*
>
> **Anna McEwen, (then) Executive Director of Support and Development for Shared Lives Plus**

Support for people with mental health support needs

People's mental health may have been adversely affected during the lockdown. These examples show how local services have reconfigured their offer:

- South West London and St George's Mental Health NHS Trust set up a 24/7 mental health emergency department for patients in crisis. A dedicated phone line enables people to attend the mental health emergency department and avoid acute hospital emergency departments.
- West London NHS Trust reconfigured an acute mental health ward to care for patients with COVID-19.

For more examples of how communities and providers have been responding during COVID-19, please see **COVID-19: adult social care and support** (LGA), **Innovation and inspiration: examples of how providers are responding to coronavirus (COVID-19)** (CQC) and **COVID-19 information for adult social care** (TLAP).

Next steps for commissioning

COVID-19 has shown that hospital discharge can be rapid and support can adapt to help people remain at home. Commissioners should help mainstream approaches that really promote choice, positive outcomes as well as deliver efficiently and at pace. Commissioners need to build evidence to understand what's helped people return home with the right support and what barriers still remain.

You can't magic this all overnight. If you are starting from a place of limited choice and collaboration, it will be about addressing immediate risks and building platforms. If you already have a broader base of choice that has worked well, this can be a springboard for next steps. Listening to people's experience is key to co-producing commissioning plans that start to put things right and plan for a more valued future. Planning for next steps must address equalities, choice, risk and assume future spikes. Starting points might include:

Reduce immediate risks

Don't invest in provision that adds extra risks. Work with providers to ensure all care homes, especially larger ones, implement plans to minimise transmission risks, but that don't make life intolerable. Don't let contract terms or poor working conditions inhibit necessary improvements. Plans should address equalities and must not compromise on quality of life. Providers should develop these with residents, staff and relatives.

What are the immediate risks to market sustainability? Co-produce contingency plans that look to the longer term to reshape a more diverse market. Money will need to move away from provision that does not deliver good outcomes for local people and local communities.

Ensure choice and develop alternatives to care homes

Choice is essential to support good outcomes for people leaving hospital. Being moved to a care home not of your choice or going home feeling afraid and isolated is not a good outcome. Many people are in the wrong place as a result of COVID-19. Help remove the barriers including retaining good joint work with health. Ensure individuals, families and discharge teams have all the support they need so citizens can go home or move on to a setting of their choice with the right support.

Plans must be inclusive of people with learning disabilities and mental health needs who still face long stays in assessment and treatment units or provision that restricts their choice and freedoms.

Urgently build community alternatives to care homes and ensure people are aware of these alternatives. With colleagues, communities and citizens, map the range of support that is available and address the gaps. What have discharge teams struggled with? Are home adaptations and tech readily available? What has worked well that can scale quickly? What sort of jobs will attract and retain good workers? Investing in good support for direct payments, community innovation such as micro-providers, self-managing teams and Shared Lives is wise commissioning at any time – they deliver better outcomes, support local economies and are **better value for money**.

Build on community connections

People are not separate to the communities in which they live and work. Many local businesses have contributed to a fairer supportive response, neighbours have helped neighbours, supposedly 'vulnerable' people have challenged and are paving a better way for others both locally and nationally. Disabled people's organisations (DPOs) have fought to highlight barriers and protect people's human rights.

Carers are part of those communities and their support is vital if people are to have the choice to remain in their own home. Many carers are at breaking point. There must be proper investment in carer support – it is the right thing to do and far less costly than if arrangements break down.

Understand the role of community support and mutual aid groups in enabling home from hospital. They are essential to connections and practical support – what do they need to continue being part of local solutions including for the longer term?

Further information

For more details about impacts and supporting better practice, please see SCIE's guide on **Care homes and COVID-19**.

An overview of key issues facing the adult social care sector in England during the coronavirus (COVID-19) pandemic is summarised in the briefing **Coronavirus: Adult social care key issues and sources** (House of Commons Library, July 2021). This includes information about the discharging of patients from hospital into care homes; rules relating to visiting care homes for friends and family of residents; the supply of PPE to the adult social care sector; and the roll-out of the COVID-19 vaccine to the sector.

See also:

Admission and care of residents in a care home during COVID-19 (DHSC, 2021)

COVID-19: adult social care and support (LGA)

Developing a capacity and demand model for out of hospital care: learning from supporting seven health and care systems (LGA, 2021)

Discharge into care homes for people who have tested positive for COVID-19 (DHSC, December 2020)

Discharge into care homes: designated settings (December 2020; updated May 2021).

Discharge to assess: the case for permanent funding (NHS Confederation, 2021)

Getting hospital discharge right (British Red Cross)

Hospital discharge (Age UK, 2021)

Implementing a home first approach to discharge from hospital (LGA, 2021)

Improving hospital discharge into the care sector (NHS England)

Innovation and inspiration: examples of how providers are responding to coronavirus (COVID-19) (CQC)

Infection prevention and control in care homes (CQC, 2021)

Living in the place we call home (Social Care Future)

People First, Manage What Matters (DTOC)

Reducing hospital admissions by improving continuity of care in general practice (Health Foundation, 2017)

COVID-19 information for adult social care (TLAP)

Understanding the impact of COVID-19 responses on citizens (SCIE, 2021)

What actions could be taken to reduce emergency admissions? (NHS England)

What happens when a person with dementia is discharged from hospital?
(Alzheimer's UK)

Support from SCIE

SCIE's COVID-19 hub contains more relevant information including safeguarding, Mental Capacity Act and infection control. It can be used when working and supporting people who are isolated or vulnerable through COVID-19, and can also be shared with community groups.

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