NHS Improvement

Rapid improvement guide to trusted assessors

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Delays in patient discharge can be harmful to patients but most can be avoided, particularly if the delay is caused by waiting for a care provider to assess and accept a patient into their service. A trusted assessor carrying out the assessment − someone acting on behalf of and with permission of the provider − is a good way of dealing with these delays.

Trusted assessors facilitating speedy and safe transfer from an acute hospital to a community or residential setting are not necessarily employed by the receiving service but authorised by them to assess on their behalf. Authorised is an important word: a trusted assessor cannot be imposed but must be put in place by agreement.

Systems that have adopted the trusted assessor model show that it can improve the experience for the patient and reduce delayed transfers of care. When delivered well, it is likely to be more personal as the assessor may be already known to the patient. It is also likely to be more timely and more appropriate to the patient's care journey as the assessor is usually located on site and can respond quickly to the request for assessment.

To create a safe trusted assessor model, care homes and hospitals should co-design and agree a protocol or memorandum of understanding for assessments, documenting who can carry them out, what competencies are required, how they will be delivered, what the review mechanisms will be and what will happen if the receiving service judges that the assessment is flawed.

It is not uncommon for patients awaiting transfer back to the care home from which they were admitted to have to wait several days for somebody to visit from the home to confirm they can still meet the patient's needs. The incorrect but common belief that the Care Quality Commission (CQC) requires this makes this avoidable, and possibly damaging, delay all the more likely.

"Where a provider is confident that they can rely on information from hospital or care management staff, and that on the basis of this information they are able to meet the person's needs, they do not necessarily need to see them in person. This includes in relation

to gaining consent to their care and treatment being transferred back to the care home."
CQC, October 2016

To achieve this some trusts and care homes have devised and agreed an assessment form that staff can complete in the hospital and the residential unit will accept. See the NHS England Quick Guide *Improving hospital discharge into the care sector* for more detail.

It is less clear whether this approach can be used with first-time admissions, and if so, how. Another part of the CQC statement refers to "Regulation 9 of the 2014 Regulated Activities Regulations, which states that before providing care, providers must complete a needs assessment in person", which appears to be unequivocal that someone from the home must complete the assessment.

Lincolnshire health and social care system came up with a co-designed solution that satisfies CQC and avoids the delays associated with waiting for individual care homes to assess. The local care association employs two people to carry out assessments on behalf of the homes it represents. For more details see the case study in NHS Improvement resources. The East and North Hertfordshire care home vanguard is piloting a similar model.

It is also possible to agree a process in which named trust staff or designated roles can carry out such assessments. This would require the residential homes to sign up formally. They would also be involved in drawing up the form used to record the assessment so that they could be sure of getting the relevant information and have confidence in the process.

This sort of model can work for transfer to residential, homes, domiciliary care, intermediate care, reablement and other housing options, and is supported by CQC. Guidance released in 2016 (in full here), states:

"However, while needs assessments of people not previously admitted to a service will normally require face-to-face contact, where an existing service user has been admitted to hospital, regulation 9 does not necessarily require the provider to physically see the person when reviewing their needs and planning the re-start of their care on discharge. Where a provider is confident that they can rely on information from hospital or care management staff, and that on the basis of this information they are able to meet the person's needs, they do not necessarily need to see them in person. This includes in relation to gaining consent to their care and treatment being transferred back to the care home."

Trusted assessors can come from a variety of professions and roles. It can be a specialist role or an extra role carried out by a variety of staff. Each situation may demand a different response. For example, one system might decide that ward staff are best placed to carry out assessments as they are likely to know the patient already and this will speed up the process. Another system might opt for a smaller number of specialist staff, eg discharge co-ordinators and/or social care staff, as they should have a better understanding of what needs can be supported outside an acute setting.

Monitoring numbers of people assessed and discharged to the community is a good start to reviewing whether the right people are doing the assessing. Sheffield Teaching Hospitals NHS Foundation Trust and Sheffield Hallam University have developed a two-day generic assessor course that involves nurses, physiotherapists and occupational therapists. If partners can input into the development and/or delivery of the training, the trust between partners and effectiveness of the process is likely to be even greater.

The *NHS England Quick Guide on Discharge to Assess* makes several references to trusted assessors and effectively states that a trusted assessor model is a necessary component of a good discharge-to-assess model. There are more examples and evidence in the guide. Although it does not deal specifically with trusted assessments, you may also find it useful to refer to the NICE guideline *Transition between inpatient hospital settings and community or care home settings for adults with social care needs*.

Summary

- Trusted assessment is a legal process if done properly. The Care Act and other legislation and guidance positively support the model. (Statutory guidance 6.3 describes a variety of ways to complete an assessment including consulting allied professionals. This is in relation to a 'needs' or eligibility assessment which has a higher threshold than the assessment we are looking at here but the point remains valid.)
- Trusted assessments are an accepted professional approach (see this community care article).
- Trusted assessment requires a co-design/co-delivery approach from involved parties.
- Be clear about the parameters of the trusted assessor at the outset. Possibly start with a restricted group and expand over time. You could begin with reablement and move onto residential care, or progress ward by ward.
- Keep it simple. For example, review all the different assessment forms being used and agree to replace with one short form. It is possible.
- Make sure there is a feedback loop. For example, if a domiciliary care agency accepts a patient based on a trusted assessor and then finds they cannot meet the person's needs, they need a hotline to someone who will help. Note: this shouldn't be seen as a failure. We should be giving people a chance to return home, and they need us to work in this way, but it does mean we will have to change the plan sometimes.
- A trusted assessor model on its own will bring dividends but much more will be achieved if it is linked to a wider change such as those outlined in discharge to assess.
- Don't assume the assessors must come from a certain staff group. Consider ward staff, therapists, social workers, discharge co-ordinators, integrated care team staff, etc.

- Set targets for an increasing number of trusted assessments completed each week, numbers of patients returning home, including with no formal support, etc, and make sure they are met.
- Be clear about who and what is being assessed. Trusted assessor can refer to different roles, including those trained to assess and organise delivery of minor equipment and adaptations. This could be a very useful extra role for the trusted assessors referred to here but avoid confusion about it.

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