The experiences of people whose discharge from hospital was delayed.

Healthwatch Reading
October 2014

Executive summary

This report presents phase one findings of a Healthwatch Reading project, which is collecting the experiences of people who have experienced delayed discharges from Royal Berkshire Hospital (RBH).

Delayed discharges (or 'delayed transfers of care' (DTOCs), as they are officially known), describe people who are medically fit to leave hospital but are delayed from doing so while assessments or ongoing care packages, such as nursing home placements, are arranged by social services. Such delays can stop new, ill patients being admitted onto wards quickly, and can also disrupt the lives of those waiting to leave hospital.

Between September 2013-March 2014, 70 pieces of feedback, were collected from seven Reading residents (and/or their relatives/carers) through in-depth interviews by Healthwatch Reading staff. Some of the case histories were shocking and prompted referrals to the local safeguarding team. This report is believed to be the first of its kind in Reading.

Key findings:

- Only 24% of the feedback praised health or social care professionals or services; no one was satisfied with the overall discharge process.
- Relatives/carers say opportunities were missed to prevent hospital admissions, particularly from sheltered housing or care homes.
- Relatives/carers did not always view delayed discharges as problems because wards provided a 'safe haven' of food and safety from falls.
- People and/or their relatives/carers say they were given inadequate or delayed information about finding a nursing or care home place.
- People and relatives/carers felt there was not enough, or any, choice of nursing home or home care provider to cater for 'complex' needs.
- People's hospital discharge was sometimes halted at the last minute because of failure to confirm ongoing care was in place.
- Some interviewees thought they were 'caught in the middle' of hospital or social care staff, who failed to communicate properly.

Key recommendations:

- Sheltered housing safety procedures should be reviewed, to check that residents can receive immediate emergency help.
- A review into attitudes towards, and knowledge about, managing falls, among care and nursing home staff, should be carried out.
- Relatives/carers should be educated on early warning signs in loved ones of worsening health, care or safety, and who to report this to.
- An information tool or service about how to find a nursing or care home should be routinely offered in good time to people/relatives.
- The RBH and Reading Borough Council should agree a protocol on how and when a discharge date is communicated to patients/relatives.
- Service users should have a strong say on future nursing home places.

Introduction

This report presents phase one findings of a Healthwatch Reading project which is collecting the experience and opinions of people who have experienced delayed discharges from hospital.

Delayed discharges (or 'delayed transfers of care' (DTOCs) as they are also officially known) describe people who no longer need acute hospital care - the 'medically fit' - but are being held up from doing so while their ongoing care – such as an RBC-partially funded nursing or care home place, or home care package, is arranged. In the past these patients have also been described as 'bed-blockers', although the term is now not commonly used.

DTOCs can prevent new, ill patients from being admitted to wards in a timely fashion, and as a knock on consequence, can prevent acute hospitals from meeting their four-hour A&E waiting times. However the pressure by hospitals to get medically fit people out of hospital, collides with the need for service users and/or their families, supported by social workers, to have time to make far-reaching decisions about care or nursing home placements where they may well spend the rest of their lives.

Reading's health and social care leaders say they are committed to tackling the issue. In April 2014 they submitted plans to NHS England to reduce the average daily number of people on the 'fit list' (ready to leave the Royal Berkshire Hospital) from 18 to 7, by October 2015. These plans are part of a wider bid for resources from the national 'Better Care Fund' and include:

- a Hospital at Home scheme to give people 24 hours of intensive support at home, instead of admitting them to hospital;
- more regular visits by named GPs to care homes to assess residents' health;
- better training for care home staff on managing residents' health;
- a 'Time to Decide' scheme, involving 15 residential nursing home beds being converted into 'step down' beds to which the hospital could more quickly discharge 'fit' patients and give social care and families more time to arrange ongoing care such as nursing home placements.

Healthwatch Reading has been invited onto various local forums on these plans to ensure the patient voice is put across as plans develop.

Project Aims

Healthwatch Reading's project aims to ensure the patient experience, as retold at the point of, or after hospital discharge, is fully understood and taken into account by health and social care leaders as they design and implement the proposals in the Better Care Fund submission.

The project also aims to inform individual services – such as social services,

GPs, the acute hospital, and care homes - how their own actions impact on the entire service user's journey in and out of hospital.

The project does not seek to 'blame' which services are responsible for the delays the patients experienced, but it does note which services the person recalled being involved for each element of their journey.

Healthwatch Reading was given access to some background information on the actions that socials services and/or the hospital generally took to facilitate discharge of service users. However these 'behind the scenes' efforts might not be reflected in this report, unless service users were specifically made aware of them by the professionals dealing with them, and/or recalled these actions during the research interviews.

Methodology

Healthwatch Reading was aided in finding interviewees by senior staff at Reading Borough Council and Royal Berkshire Hospital staff, who identified people recently discharged or awaiting hospital discharge, and who also sought consent for their details to be passed to Healthwatch Reading/or to be approached on a hospital ward.

Healthwatch Reading then solely undertook the process of contacting interviewees, obtaining signed consent, interviewing, and writing the findings.

Healthwatch Reading development officers visited people and/or relatives/carers in their own homes (or carried out telephone conversations where visits were not possible or wanted) to carry out semi-structured interviews. One Healthwatch Reading officer asked questions while the other took notes. Interviews typically lasted an hour.

All, bar one, of the interviews was carried out after hospital discharge; the other was undertaken in hospital, days before a planned discharge date.

People were asked to recall the discharge process by giving recollections on:

- what information they were given about when they would be discharged, and by whom, and at what stage of the hospital stay
- whether the information told them everything they needed to know
- whether they were assessed by any health or social care staff to help plan their post-hospital care needs
- the hospital experience, such as the quality of care, food, and the physical environment
- the quality of the care or nursing home, or home care package and any other follow up they received after being discharged.

They were also asked what was the most important change or improvement, if any, they would suggest be made to the hospital discharge process.

Findings

Healthwatch Reading collected 70 separate pieces of feedback from seven interviewees.

Just over half of the feedback (57%) related specifically to the service user's experience while in hospital waiting for discharge. The next biggest category of feedback (41%) related to pre-admission care, and the rest of the feedback was about experiences after discharge.

Healthwatch Reading believes it is important not to exclude pre- and post-hospital discharge feedback from this report, as it helps paint a picture of people's journeys through various parts of the health and social care systems, as well as highlighting potential missed opportunities to prevent admissions.

Seen in isolation, some of the negative experiences reported by service users might appear relatively minor, but they may be the latest in a long line of experiences that leave a long-lasting, negative impression.

Of the 70 pieces of feedback, 17 (24%) specifically praised staff or services.

Feedback about pre-admission care

Many of the interviewees were keen to volunteer information about their (or their relative's) past experience of health and social care, some going back years. Many described what they saw as failures by services to respond to crisis situations, or to potentially prevent admission to hospital.

Three of the seven people had a similar history of being admitted to hospital from their sheltered housing accommodation:

> *"At the sheltered housing flat, he was needing more and more help. The day he went into hospital we'd got someone to price up removing the carpet and replacing it with vinyl, to cope with his toilet issues. He had seen the GP but without one of us there at every appointment - someone who represents him - to ask the right questions…Someone should've said to social services his needs had changed. It's our responsibility too….He fell out of bed, rang the bell, nothing happened and he was stuck under there for hours, bruised. When he got to hospital they found he had a UTI [urinary tract infection], which probably caused the fall."*

"I had thought on various occasions, after she'd had the stroke, that things weren't quite right. She'd suddenly stare into space and go all lopsided. If she was sat on a chair I'd have to prop her up or else she'd fall and many times I'd think, 'There's something going on here', but nobody would listen to me - even though I was the only one that ever saw what was actually happening."

"It's [the service user's sheltered housing flat] got a pull-cord. But a couple of times I phoned, she didn't answer. She'd fallen down and couldn't get back up. One time she fell behind the door and my wife couldn't get in."

Two of the service users had been admitted to hospital from care homes, one after repeated falls.

"One day we went in and she had this lump on her head and a black eye, all down her face. I went to get somebody [who worked at the care home] and said, 'What's happened to Mum?' because usually they should ring me. She just looked up at me and said: 'Oh, she's been moving her furniture and probably fell over.' She wouldn't get up to come and see so I grabbed two of the other carers and I brought them into the room to show them Mum's face. They said, 'Oh [service user], what have you done?' and I said, 'Well, what has she done?' and one of them said, 'Well, she wasn't like this this afternoon'. Nobody had noticed."

The other person who was admitted to hospital from a care home said hospital staff had told him they were concerned about his malnourished state on arrival. The service user said he had disliked the food at the home. He had also failed to respond to antibiotics.

A daughter of another service user said her mother's hospital admission came after her pleas for a respite care home place - where her mother's ability to safely self-administer her medication could be monitored – was turned down. An overdose of medication by her mother had resulted in a previous, recent hospital stay:

"I begged for her to go into respite care. They said they would up the [home] care to an extra 15 minutes [visit] per day to allow her to go home [from hospital]. I warned them she would fall again and to the week…she fell in the kitchen."

Feedback about the hospital stay: overall care

Most praise given by interviewees about services related to care that they or their relatives received in hospital. Families reported how their loved ones started to eat properly again, regain strength and were in a place of safety. This was particularly a source of comfort if their relative had had a poor diet or repeated falls in their sheltered housing or in care homes. This perception of the hospital as a safe haven often offset any concerns about the service user's delay in leaving hospital.

"One morning she was so bad the doctor called us in to sign forms about whether we wanted her resuscitated. This went on for a fortnight, three weeks. Then one day I walked in there and there she is eating a roast, drinking a cup of coffee, right as rain. The hospital care, I can't fault - they did have a shortage of staff at weekends, but that isn't their fault is it? She was kept clean and they got her to eat - which they should have been doing at the care home."

"At the time I was thinking, 'Thank goodness she's in hospital being looked after.' She started eating again, proper food, instead of just tea and biscuits.'

"Mum didn't mind being in hospital. She was continually looked after, given three meals and she got a lot of care and attention."

Feedback about the hospital stay: the discharge planning process

Praise was volunteered about some of the individual social workers trying to arrange post-hospital care. However, none of the people (or relatives/carers) praised the overall hospital discharge experience:

"The social services side of it was very good. Their heart is in the right place. She [the social worker] was a very good lady, a very bright lady. But the system is not designed for speed. It's very, very slow. The system hasn't been designed properly. Each step of the way should have prescribed time limits."

Overall, people found the process of being discharged bewildering. The main problems reported by people (or relatives/carers) were:

- Not being sure if they or social services were responsible for finding a nursing or care home place and who would pay for this.
- Not being sure how to start finding a care or nursing home best for them, and how to independently check the quality of that home.
- Care and nursing homes or home care agencies not appearing able or wishing to take on 'complex' cases.
- Being told that no local places were available.
- The hospital telling patients and/or the families that the service user was leaving on a certain date when a placement or package of care had not yet been agreed.
- The hospital not appearing to talk to, or be able to get hold of social workers to confirm discharge dates.
- Being placed in homes or with home care agencies they had been given no information about, apart from location and/or name.
- Not being 'allowed' to be discharged at the weekend.

"The hospital said to me, 'Have you got anywhere [a nursing home] yet? I said; 'Have I got her anywhere?' I said, 'No'. Apart from someone saying to me 'She needs a nursing home' [no-one had told her she was responsible for finding the place – she thought social services were]."

"This social worker, she kept phoning, saying 'We're going to sort out a nursing home', we're going to do this, we're going to do that - and that's all it was. It took them an awful long time to set to and do it. And there was the excuse, 'Well, it's Christmas', but I'm sorry, we all know the date of Christmas, it's been that date forever. Maybe I'm too organised a person, but it winds me up when people say 'I'm busy' - well it's your job, sort yourself out. I'd get the hospital on the phone saying, 'Have you got any information? Did I know if she was going to be able to go home?', and I'm thinking, 'Why are you phoning me?' If it was in my power I would have dealt with it, but it's not, I'm only the stepping stone [to the service user]."

"I didn't have a clue [when service user would be leaving hospital and to where]. I had to rely on my daughter [to find out what was happening]. She had to call them and they would say they would ring back, but they wouldn't."

"If you look on the Internet at homes, the majority of them say they will take [people with] dementia, but with no other problems. But my mum wasn't a normal dementia patient where she sort of forgot people and could sit and be entertained. She had a mental health problem."

"The hospital kept ringing me, saying she'd be going on Saturday, and I'd say, 'No, I've not got her a place yet'."

"They [social services] couldn't get anyone to accept the [home care] tender. I thought there'd be plenty of agencies wanting work, but then there's also the complication of her situation [of needing a visit every four hours for medication administration]. It took a bit of pushing in the end."

"Nobody gave us choice [over the home care agency that would be used]. We were told, 'This is the only people who can do it'."

"Before home care starts, you should know the details of the company supplying it. I don't know who is coming, whether it will be the same person or different for each visits. They will have keys to my home, but they are strangers."

"Twice I was told she would be discharged at the end of the week, but she wasn't. Then I was suddenly told, she could come out tomorrow, 'Can you pick her up?'…. It seems as soon as they had the care package in hand, it was time to 'get rid'."

"The hospital could get their act together more. The right hand should know what the left hand is doing. I would have a matron ringing, saying, 'She's ready for collection at 1pm' and obviously the message from one shift to the other [that the SU was not allowed to leave because she had a safeguarding order on her] hadn't passed on…..They would also be telling my mum, 'You're going home after dinner and then she would ask me, 'Am I coming home?' and I would have to say, 'No, you can't yet'. You can't do that [give wrong information] to a person with mental health problems."

"No way [was SU going to go to a nursing home in Newbury, Camberley or Slough]. My family can't be expected to travel that far to see me."

"You just want some sort of idea of what [type of nursing home] you're going into it. It's an unknown place."

"I would've liked to have gone home for Mother's Day [on the Sunday]. But the hospital advised me that 'Sunday is not a good day to go home, in case she falls and needs further help'."

"In the end we went for [care home in Reading] but they couldn't get her in for a fortnight because one of the other people that was on respite [in that care home] was in a bad way and they were staying on, which was fair enough. But the hospital said she was due out Saturday so we found [a different home in Maidenhead] that would take her and transfer her [back to Reading] when the place came up. They were going to assess her in the hospital but they couldn't because there was a hospital bug - we couldn't visit her either. In the meantime, the [original] place came up."

"It's all so disjoined. It's unbelievable. There's too many chiefs and not enough [staff] and none of them talk to each other."

Feedback about post-discharge care

A variety of feedback was volunteered about the care that people received after being discharged from hospital, ranging from praise for follow-up visits at home from GPs and district nurses to check leg wounds, to concerns about growing dependence, and also serious concerns about dehydration.

"I think more proactivity could have helped [keep him more independent]. When he was in hospital, he was vaguely mobile, he could use a [walking] frame. But when he went to [the first care home], nobody encouraged him to walk and the frame he was given seemed to be in need of repair. My point is - look at the cost of somebody who can't move - he needs three people to move in and out of bed - versus the cost of intense phsyio to help him keep more mobile and independent. It seems it's too late and his mobility is gone."

"I liken it now to looking after a child. She keeps saying, 'I'll wait till you, or [home care worker] come', instead of doing things for herself, like making a cup of tea."

"Initially the home care was pretty poor timing, It would be 9am, 9.30am, even 10am once, before they first came, and she would be sitting in bed saying, 'Am I allowed to get out of bed?' She thought she had to wait. The visits were squeezed together, not to mum's timings [of meals/routine]. When I first complained the agency said the care worker's car had broken down, or she had got stuck in traffic."

"The two moves [from the care home to the nursing home in the space of two months after the hospital discharge] have had a huge impact on him. We can't blame anybody in particular for the two moves as the system obviously doesn't want to dole out funding for nursing care to anybody, they have to be careful where to allocate funding. With him, it just turned out that his needs were more than originally thought."

"I was shocked at the state of [her, in the care home she was discharged to] because she'd lost such a lot of weight. Her lips were absolutely snow white, and I thought, perhaps she'd had sore lips and they'd put cream on it. Then the girl [working at care home] brought the cups of tea round and slices of cake. We said to [service user], you eat the cake, and she didn't know what to do with it and so we were feeding her. The same with her tea. I think they must have been plonking it in front of her, and perhaps by this stage her sight was so bad she didn't realise it [the tea] was there…so I realised that her lips…she must have been dehydrated, very dehydrated."

"When we said goodbye to her, we called into the office en route to say we're got personal items to take back to her room. That's when the [member of staff] physically tried to stop us. She was really rude and abrupt and to my mind, it doesn't matter who it is or how elderly they are, if they've got a few personal belongings around them, it just makes it appear more homely. In the end I said, 'I'm sorry, I'm going to carry on'. We put her toys on the bed and brought her shower gel and nice powder, just ordinary things we thought she might have needed."

Discussion and recommendations

Sample size

The number of completed interviews to date is 7, which may appear insignificant. If these interviews had been carried out on a single day, they might have represented 38 per cent of the average daily number of people who are on the 'fit list' awaiting a discharge.

A Health Foundation study published in March this year notes that there is no single 'silver bullet' for measuring person-centred care[1]. It also cites a UK study comparing a postal survey of 82 patients with 13 narrative interviews. It found that surveys may be useful as a screening tool to identify potential problems, but they do not provide sufficient detail about what needs to be done to improve services. The study went on to recommend that surveys be used as preliminary tools, with better use of open-ended comments, followed by in-depth qualitative interviews and analysis to 'capture the multifaceted nature of patient experience'[2].

The interviews conducted by Healthwatch Reading were time intensive and required the use of half of its team of officers, for each visit to a person's home. The goodwill and time of RBC and RBH staff was also required in identifying potential interviewees.

Given the large amount of feedback generated by the interviews, Healthwatch Reading believes there is value in carrying out further interviews, particularly of those still in hospital, to capture more 'real time' experiences. This would require the same helpful facilitation from a ward matron on an RBH ward that was offered to Healthwatch Reading during phase one.

It should also be noted that findings of a special inquiry into discharge from health and social services, of vulnerable people who are elderly, homeless or who have mental health problems, are due to be published in September 2014 by Healthwatch England, based on the feedback it receives from the network of local Healthwatch across England.

Warning signs

The feedback shows that families often spot signs or have an inkling that their relatives are at risk of a hospital admission, but are not sure how or when to act on this. Healthwatch Reading would ask services:

- How many falls should a sheltered housing resident experience before the sheltered housing manager/staff, or family, or GP, alert social services so they can assess whether it is still safe for them to live in such accommodation?
- Is it ever acceptable for a pull-cord or alarm that has been activated by a resident to go unanswered for hours?
- Who should be the first port of call for a relative or friend to raise concerns, and how will they know in advance who this is?
- Do care home staff see falls as just 'one of those things' that happens?
- How could families and friends be educated on potential signs of a urinary tract infection?

[1] The Health Foundation (2014) Helping measured patient-centred care; pg2; London
[2] BMC Health Serv Res 2012;12:271

Information gaps

The feedback shows that relatives of people in hospital who will need to be discharged into a care or nursing home, need to be given a lot of information about how to embark on this process in a clear, easy-to-understand and pragmatic fashion. They do not want to infer what they have to do from rushed telephone conversations from social workers, nor do they want to make wasted trips to care homes that turn out to be unsuitable for their relative's needs.

A number of options for the future should be considered, which could be used in either a hospital setting, or in the 'Time to Decide' step-down model being proposed. These options include:

- An information pack that pools together existing, but separate council leaflets, on choosing a care home, selling your home to pay for a care home, and paying for a care home.
- A brochure or web-based list of all potential residential or nursing homes in Reading which gives detailed information on the complexity of needs they can or cannot cater for, and their current CQC rating, to aid service user/family choice
- Dedicated face-to-face meeting with social worker/information officer to discuss needs, options, finance, and local intelligence on place availability
- Signposting people to an external information/advocacy service to give families independent advice on finding homes.

Similar information options should also cover home care packages that are being arranged for service users leaving hospital, and should include the latest list of 'DASL' providers that have been approved by the council.

Information gaps

Service users told Healthwatch Reading that one of the most frustrating things they experienced was being told the service user was going home when it later transpired not to be the case. This caused inconvenience for family members who might need to take time off work to assist with the discharge, left mentally vulnerable patients more confused and distressed, and left a negative impression on family members who felt that health and professionals just did not talk to each other.

Healthwatch Reading believes a concerted effort is needed by staff at the Royal Berkshire Hospital and Reading Borough Council to improve the way they communicate with each other about individual cases and the actual discharge date.

In particular, patients or relatives should not be put under direct or implicit pressure to sort our delays that are out of their control.

People who are 'too hard' to place

This project also raises longer-term questions about whether the right type of care is available for people leaving hospital and whether this will need to change in the future.

As one person's daughter put it, her mother was not a 'typical' dementia patient and had more complex needs which she felt that local nursing homes did not want to take on. Another person's daughter described her surprise that it was difficult to find a home care agency to meet her mother's need for medication administration every four hours.

RBC's latest Joint Strategic Needs Assessment states that new nursing homes will need to be built in the future to meet the needs of people with dementia.[3] Healthwatch Reading urges commissioners to ensure these new places, as well as the new group of home care agencies being retendered, include provision for complex case.

Key recommendations

- Healthwatch Reading should continue to carry out in-depth interviews of people awaiting hospital discharge.
- Sheltered housing safety procedures should be reviewed, to check that residents can receive immediate emergency help.
- A review into attitudes towards, and knowledge about, managing falls, among care and nursing home staff, should be carried out.
- Relatives/carers should be educated on early warning signs in loved ones of worsening health, care or safety, and who to report this to.
- A common information tool or service about how to find a nursing or care home should be developed and routinely offered in good time to people/relatives
- Royal Berkshire Hospital and Reading Borough Council should agree a protocol on when and how a patient is told their definite discharge date. The protocol should cover how hospital staff can quickly get confirmation from social workers on whether nursing or care home placements are ready.
- Service users' views should strongly shape what kind of nursing home and home care is commissioned in the future in Reading

[3] Reading Borough Council (2013-2014) http://jsna.reading.gov.uk/ section on Residential and nursing care provision.

Summary

Healthwatch Reading believes phase one of this project has uncovered strong evidence directly from people who use services, which the hospital discharge process needs urgent reform.

People have also volunteered extra evidence beyond the initial scope of the project, that points to serious failings in settings such as sheltered housing and care homes to protect the health and safety of vulnerable, older people.

Healthwatch Reading urges health and social care commissioners and providers to act swiftly to transform the patient experience.

Acknowledgements

Healthwatch Reading thanks the patients, services, families and friends who gave their time to be interviewed for this project. Healthwatch Reading also thanks key personnel at Reading Borough Council and Royal Berkshire Hospital, who sourced potential interviewees, and also the RBH staff who facilitated a Healthwatch Reading visit to a ward to carry out interviews.

Responses from services/providers

The Reading Health and Social Care board, comprised of leaders and/or senior managers of health and social care services, submitted a six-page response, plus an action plan, to Healthwatch Reading, on 30 September 2014. The response and action plan is printed in full, overleaf:

Developing better integrated care

Response to the Healthwatch Reading report: *The experiences of people whose discharge from hospital was delayed*

Reading Health & Social Care Board

October 2014

Foreword

A report was prepared by Healthwatch Reading in April 2014 following a series of in-depth interviews with seven people whose discharge from the Royal Berkshire Hospital had been delayed beyond the point when they were medically fit for discharge. Family members and friends were also interviewed to give feedback from their perspectives.

Healthwatch's report was discussed at the Reading Health and Social Care Board on 3rd June, 2014. This Board brings together senior officers overseeing the delivery of care across local organisations, and directs the Reading Integration Programme which aims to co-ordinate health and social care services around individual need. The Board welcomed Healthwatch's insights into the patient / customer experience, and directed Reading's Integration Programme Manager to work with partners to develop an action plan to address the issues highlighted. This action plan will be monitored through the Reading Integration Programme Board, of which Healthwatch is a member.

The negative experiences which Healthwatch Reading reported are precisely those which Reading's Integration Programme has been set up to tackle. The programme includes reducing delayed discharges from hospital as one of its priorities. It also includes reducing avoidable admissions to hospital, another area highlighted in Healthwatch's findings. The programme has been developed from a vision which was set out in Reading's Better Care Fund submission, first approved in outline by the Health and Wellbeing Board in February 2014, and which has since become one of the national BCF fast track plans. This local vision is to provide the right care by the right people at the right time and in the right place.

Our integration programme is intended to put the person at the centre of how services are designed and delivered. Healthwatch's findings are a timely reminder of how vital this is. As Chair of the Health and Social Care Board, I will retain oversight of the integration programme to ensure we do not lose sight of this.

Ian Wardle
Managing Director
Reading Borough Council

Heathwatch's Key findings

- Only 24% of the feedback praised health or social care professionals or services; no one was satisfied with the overall discharge process.

- Relatives/carers say opportunities were missed to prevent hospital admissions, particularly from sheltered housing or care homes.

- Relatives/carers did not always view delayed discharges as problems because wards provided a 'safe haven' of food and safety from falls.

- People and/or their relatives/carers say they were given inadequate or delayed information about finding a nursing or care home place.

- People and relatives/carers felt there was not enough, or any, choice of nursing home or home care provider to cater for 'complex' needs.

- People's hospital discharge was sometimes halted at the last minute because of failure to confirm ongoing care was in place.

- Some interviewees thought they were 'caught in the middle' of hospital or social care staff, who failed to communicate properly.

Responses to Healthwatch's key recommendations

(1) Sheltered housing safety procedures should be reviewed, to check that residents can receive immediate emergency help.

> **Keeping vulnerable residents safe is a high priority. Equipment is checked regularly, and we have carried out the review of procedures as recommended.**
>
> **Both sheltered housing and extra care housing services managed by RBC and other landlords have processes in place to contact residents proactively, and to act should residents require additional support. It has been agreed that these processes should be developed to add in the following points.**

- **When gathering information about those close to the resident, staff will ask the resident about their wider network of support and record this provided the resident agrees.**
- **Staff will review the availability of phone number/ contact information for housing support staff to ensure friends and family have clarity about who they can contact about concerns e.g. by putting posters up in lifts and common areas.**

(2) A review into attitudes towards, and knowledge about, managing falls, among care and nursing home staff, should be carried out.

Reading's integration programme includes a project to develop skills and capacity amongst care home staff to prevent hospital admissions. Improved falls awareness and management is a key element of this, and Reading's Integration Programme Manager now has oversight of Reading delivery of this project, which includes the other Berkshire West localities.

In addition, Berkshire Healthcare Trust will work with the Council to raise the profile of the local falls prevention service and will send information about the service to all domiciliary care agencies and carers groups. The CCGs have recently invested in a new falls liaison service for follow up and prevention of subsequent falls in people who have had a previous fracture.

(3) Relatives/carers should be educated on early warning signs of worsening health, care or safety, and who to report this to.

We recognise that clear information about managing various health conditions or issues is an important service for family carers, as well as for the relatives they support. We aim to help carers access the information or training they need in this regard through our carers assessment process, as well as supporting a range of community groups which provide carer-specific support or peer support for people with long term health conditions and their families.

We are currently reviewing local information and advice for people with care needs (see below) and within this will look at how we can develop the information available about warning signs and improve timely access.

(4) An information tool or service about how to find a nursing or care home should be routinely offered in good time to people/relatives.

The Council currently produces a number of information leaflets about care and support services, and also hosts the online Reading Services Guide which contains information about a wide range of services likely to be relevant to people with care and support needs. In addition, there are both Council teams and Council-funded community organisations who support people to understand their care choices.

The Council is currently reviewing local information and advice about care choices, including on finding a nursing or residential care home, as part of its preparations to meet new obligations under the Care Act which come into force from 2015. Within our information and advice review, we aim to identify key times and places when people need personalised or focused information. We appreciate that there are times when too much information can be as unhelpful as too little and people may need extra support to identify what is relevant in their current circumstances.

(5) The RBH and Reading Borough Council should agree a protocol on how and when an estimated discharge date is communicated to patients/relatives.

This is something with the Integration Programme Manager has been exploring with the various care staff who may be involved in hospital discharge. Improving the patient experience of moving on from acute hospital care is one of the key objectives of the Integration Programme, and all agencies are now working to give patients an estimated discharge date within 24 hours of their arrival.

Discharge dates will change, however, such as when people become unwell, and good communication between all parties is essential. To this end, the joint health and social care policy on transfers of care is being reviewed. The refreshed policy will be available by the end of October, and will clarify the responsibilities of staff members from all agencies and the timescales for action. It will also include a flow chart for patients and relatives which describes the process. This will cover both acute and community hospitals throughout the Berkshire West area.

(6) Service users should have a strong say on future nursing home places.

The Council's aim is to support anyone looking for a nursing home place to exercise choice and to find the most appropriate place to meet individual needs. We realise, however, that service users and their families may feel under pressure to make decisions at the time of hospital discharge, which is why we have developed the 'Time to Decide Beds' project within our Better Care Fund proposal. The intention is to enable people who may need ongoing nursing care to be discharged from hospital as soon as this is safe, but then be supported to make the best choice about meeting their long term needs. The details of how this will operate are now being developed.

Additional actions identified

Developing an action plan in response to Healthwatch's findings has helped organisations to identify other ways that the links between sheltered or extra care housing and hospital could be strengthened. The following points were therefore added to our action plan.

- The hospital discharge team manager will forward information about the hospital discharge service to all sheltered and extra care settings in Reading.
- Sheltered and extra care services will amend their processes to make contact with wards, and the discharge team, when individuals are admitted to hospital. The aim will be to ensure that healthcare staff know of the housing staff involvement and can seek

agreement from the resident to their being contacted when discharge is planned.

- An information sheet will be sent to wards by housing providers (with the resident's permission).
- An information sheet / checklist will be developed on the process for giving up a tenancy and clearing homes to assist those moving into residential care, and their families.

Although Healthwatch concentrated on the experiences of patients in the acute hospital, Berkshire Healthcare Foundation Trust will take this learning and the issues highlighted to improve internal discharge processes within Mental Health and Community hospitals. Berkshire Healthcare Foundation Trust will also embed the key recommendations into their discharge processes to ensure timely contact is made with the various housing providers prior to discharge.

Reading Health and Social Care Board response to Healthwatch Reading report: Action plan September 2014

Report Recommendation	Actions	Lead Team/ Organisation	Date for Completion	Progress (September 2014)
Sheltered Housing safety procedures should be reviewed to check residents can receive help in an emergency	Information sheets to be created and displayed in foyers and entrances of sheltered housing units.	RBC Sheltered Housing team/ A2Dominion	31.10.2014	A2D information sheets are being developed and will be in place for start of October. RBC sheets are being updated and will be completed by end of October
	When gathering information about those close to the resident, staff will ask the resident about their wider network of support and record this with the resident's consent.	RBC Sheltered Housing team/ A2Dominion	31.10.2014	A tool is being developed to record information on residents' support networks
A review into attitudes towards and knowledge about managing falls amongst care and nursing staff should be carried out.	RBC's Contracts and Commissioning Team to disseminate information on BHFT Falls Prevention service in information to care providers. Falls prevention flyer to be shared with carers groups to ensure informal carers are aware.	Community Reablement Team (RBC & BHFT)	31.12.2014	Falls prevention information shared between BHFT and RBC, who will disseminate to care providers and to carer groups by end of December
	RBC's Quality Performance Monitoring Team to continue to review care plans including mobility and recording of falls.	RBC Quality Performance Monitoring Team	Ongoing	The team robustly review care plans and how falls are recorded. The QPM risk based monitoring tool includes falls, which is routinely raised with providers
An information tool or service about how to find a nursing or	Review the current information and advice on offer to map gaps and areas for further work	RBC Adult Social Care	31.08.2014	Review of current offer and areas for development identified
	Work with residential care providers to develop the listings on the Reading	RBC Adult Social	31.12.2014	Work to develop the Reading Services Guide is

care home should be routinely offered in good time to people/relatives	Services Guide (RSG), and to add more detail such as size of the home	Care		ongoing, but providers have been contacted to add to their records
	Add information to the Council's ASC leaflets and RSG that will help people to understand the type of support that they might have & the process	RBC Adult Social Care	31.03.2015	Information available in existing resources (e.g. Age UK leaflets) identified, to be used to redraft the Council's leaflets and web pages on ASC
	Check the information currently offered across teams to ensure consistency (e.g. promoting the Reading Services Guide)	RBC Adult Social Care, RBFT Discharge Team	31.12.2014	Meeting to be arranged to review what information is provided currently, and raise awareness of information sources like the RSG
Reading Borough Council (RBC) and Royal Berkshire Foundation Trust (RBFT) should agree a protocol on how a discharge date is communicated to patients	Developing a policy regarding Transfer of Care flow charts, which agrees: • Partner/Agency communications to Service Navigation Team (SNT) with discharge details • SNT responsibility to communicate details with the ward, who communicate with the patient and family	RBC Adult Social Care, RBFT Discharge Team	31.10.2014	Draft policy ready for final comment by all agencies, prior to sign off by all agencies by end of October
Service Users should have a strong say on future nursing home places	Introducing Discharge to Assess beds (part of Better Care Fund development)	RBC Integration Programme Manager	31.12.2014	Trial of Discharge to Assess bed now in operation – to date 3 people have benefited and in 2 cases this has led to a change of discharge plan from care home to

				support in own home. Planning still underway for 3rd person The scheme will be implemented by December.
Enhance joint working between Housing and discharge planning teams	Exchange contact details between Service Navigation Team and sheltered housing and extra care housing providers Share a list of sheltered housing and extra care housing units with hospitals	RBC Adult Social Care, RBFT Discharge Team	31.10.2014	Staff have been informed of contacts in housing and hospital discharge teams List of sheltered and extra care units have been sent to hospitals
	Develop a process for surrendering tenancies in sheltered housing or extra care housing	Intermediate Care Team	31.12.2014	Meeting arranged to develop a process for surrendering tenancies