healthwatch Coventry

Experiences of discharge to assess pathways in Coventry

SUMMARY REPORT

June 2019

1) Introduction

Healthwatch is the champion for users of health and social care in Coventry. We give local people a voice - making sure that patients, service users, carers and public views and experiences are heard.

We are independent of NHS and care services and decide our own programme of work. We work to influence the planning and delivery of NHS and social care services based on what local people tell us.

This report presents the experiences of 47 people and enables the reader to hear their voices, feelings and views about the care they received. The people we spoke to were some of the frailest and most vulnerable, who sometimes do not have their voice heard. A considerable amount of time has been spent by Healthwatch staff and volunteers gathering in depth information.

The Healthwatch Coventry Steering Group added this piece of research to the Healthwatch Coventry work Programme for 2018-19 because of feedback related to the home support element of the Discharge to Assess; issues highlighted through other work and because we could not identify any other mechanisms by which those experiencing these services were asked for their views/feedback.

2) What is discharge to assess

In Coventry the name 'Discharge to Assess' refers to 3 programmes (pathways) of care/support aimed at either enabling individuals to regain their ability to live independently or to have their ongoing care needs assessed once they are discharged from hospital.

Reablement also known as 'enablement' or 're-enablement' is intensive short-term support to help people to relearn daily skills and regain confidence to live independently. Daily skills could include preparing meals, washing, dressing and toileting. It uses a therapy model and is intended to enable people to remain in their own home as independently as possible.

For those who have higher levels of needs and therefore are less likely to be able to safely live independently a period of up to 6 week allows for the assessment of care needs for the future with the aim of identifying where that care will be provided. Assessment away from the hospital environment acknowledges that people often function differently once outside the hospital environment.

Services provided in Coventry

The discharge to assess model in Coventry has been operating for approximately three and a half years from June/July 2016 and it is jointly commissioned by Coventry City Council and Coventry and Rugby Clinical Commissioning Group (CCG). There are three programmes or 'pathways' each with commissioning leads. A summary of the discharge to assess pathways can be found in appendix 1.

3) What we did

Our work took place between October 2018 and February 2019. We looked at the 3 pathways (programmes of care) by:

1) 10 visits to the care home providers of this care: Bablake House, Sovereign House and Charnwood House to carry out observations, interviews with managers, therapists, care home staff and patients and relatives

2) Visits to four Housing with Care units: Harry Caplan, Knightlow Lodge, Quinton Lodge and Cottage Farm Lodge. To gather the views and feedback of managers, staff and people on their reablement journey. A group meeting with Housing with Care service managers was also held.

3) Interviewing the managers of the 3 home support agencies providing this service: Radis, Accord and Sevacare.

4) Coventry City Council identified sent out a letter and participation consent form on our behalf to 203 people who had used reablement support in their homes. We then did interviews by phone or in person, visiting people in their home or provided a self-completion survey.

5) We interviewed a care home manager responsible for pathway 3: discharge to assess and we interviewed three people within a care home on pathway 3.

6) We spoke to the Head of Commissioning and Provision at Coventry City Council. We also met with the Clinical Commissioning Manager and Clinical Lead, Discharge from Acute Beds/Brokerage for Continuing Healthcare from Coventry and Rugby CCG in February 2019 – near the end of our piece of work.

4) What we found

We spoke to 47 people who were either using services or were relatives of people using services.

Location	Number
Care in own home	13
Care home	24
Housing with care	10
Total	**47**

5.1 Reablement in the home environment

The key points from our conversations and observations regarding the support provided in peoples own home for reablement (pathway 1) are:

- All of the providers saw the Multi-Disciplinary Team approach as a good way of working as it facilitated being able to share information and supported decision making

- Service users were sometimes discharged from hospital without the correct medication or without equipment at home to enable them to be safe. Issues were also highlighted about people not being discharged at a time when care support staff would be able to begin their package of care

- Queries were raised about whether people were discharged on the correct pathway because:

    - Some people were returning to hospital following illness and starting the process again
    - Some people seem to be on a repeat cycle
    - Some people need palliative care at end of life

- There was mixed picture about how informed patients felt prior to hospital discharge about what was going to happen

- We did not feel that we had a clear view of how people were involved in setting their goals and plans and whether these reflected the person's views and opinions. We were also unsure whether their goals continued to be supported within reablement packages

- Some people said that care staff did things for them rather than supporting them to build their skills/confidence in every day tasks.

- Respondents highlighted the following areas for improvement:

  Therapy
  "More time with physio, more time to do things myself knowing someone is there in case falls"
  "More physio … More communication"

  Care:
  "Not quick enough response time in attending to his needs"
  "The response time when needed would sometimes be too long e.g. toilet requirements"
  "Surely an agreement could be worked out that carers attend at reasonable times, not too early and not too late"
  "Perhaps a little more time, but I know everything as always busy and there are a lot of people worse off than me, so that is why I am grateful. Thank you"

Communication:
"Telling clients approximately when they can expect a carer"
"They all filled in a book but despite three phone calls have not collected it. I finished 'care' in mid October or thereabouts"

5.2 Reablement in a housing with care flat

The key points from our conversations and observations regarding reablement pathway 2: care within self-contained housing with care flats were:

- Some staff felt there was a considerable delay before Occupational Therapists made their first visit, and this often had to be chased up. This impacted on a person's progress.

- Various issues were raised about the quality of referral information (from hospital) and this not necessarily having all the information needed:

    - Equipment needed
    - Care needs
    - Medical background that may impact on communication/care needs
    - Health status

- Staff suggested that more information was made available to people before they are discharged from hospital or when planning their stay to ensure that firstly they are clear about what short term bedded accommodation is and the reason they are going and secondly that they have all the practical things they need for their stay (the everyday things that we all use at home)

- All respondents said they were not given any written information on arrival or during their stay in housing with care (other than the support plan). No one had been given a particular point of contact. Most people thought that they would just speak to one of the care staff that came in at certain points of the day or ask a family carer

- We identified that unit staff felt they could not always complete support tasks within the allocated time they had: for example, when tasks are set like 'walk the corridors' to improve mobility skills

- All of the people interviewed knew that there was a support plan in their flat, but only one person said they knew what was in it. Seven out of the nine people interviewed had family members providing input into the support planning process. Only two people were clear about understanding the support they had received from an Occupational Therapist

- The accommodation needed updating and its physical location and layout could be a challenge. It was suggested that putting a TV in the bedrooms would be a

good idea as this reflects normal life and would also reduce the problems staff have when creating a rota of times people are supported to get into bed.

- Staff thought it would be helpful if medication arrived in blister packs as this would reduce the time staff spend recording information about medication that people bring with them when they arrive. It was described by one member of staff that *'some people bring bags and bags of medication with them*".

- Generally, all residents interviewed felt they were treated with dignity and respect apart from two instances two people described to us.

- It was clear from findings the feeling of being safe, not worrying and having their own private space were the most important things to residents.

5.3 Reablement in a care home bed

In summary the things we found from our visits to the three care homes providing pathway 2 reablement care were:

- Many comments about positive working relationships and multi-agency team working

- Only a few patients/people could answer positively when asked if information had been given to them in a way they could understand

- In all three care homes residents on reablement packages said they had been treated with dignity and respect

- Out of the 21 people interviewed 7 people said they would participate in activities taking place within the care home. People gave a variety of reasons for not taking part in activities from their unwellness, *"lack of confidence"*, not being aware of activities, to a sense that they were different from other residents

- We received three negative comments about the food at Bablake House two negative comments about the food at Sovereign House

- Of the people interviewed just three people said they were involved in conversations about ongoing care. Five people were able to give us some indication of when they would be discharged from the home/reablement package. One person said they had become a permanent resident.

- People gave us the following comments about what was positive and what could be improved:

Positives

- *They take care of you, food's not too bad, got a nice room the bed is comfortable*
- *Occupational Therapist, who was very efficient, sensitive and made a positive difference*
- *Fact that knew someone there at the touch of a button – someone who cares and can help*
- *the way that they look after you, can talk to people if you have a problem, even the carers are lovely*
- *[the home is] Comfortable and safe*
- *Nice and quiet resting my leg, it's alright*
- *Everything is done for you. Take you to where you are going*
- *I feel safe*
- *Everybody so kind*
- *Nice place - better than hospital more liberty*
- *The food*

Suggestions for improvement:

- *Done in own home*
- *Could have hearing aid in*
- *Person who is individual for you, food could be better, had to ask for a table lamp so that I could read at night*
- *Want to have hair washed*
- *There are not enough staff*
- *Either too much social worker co-ordination or too little info.*
- *Don't always understand how the system works*
- *Better seats - more padding!*
- *Took a long time to order equipment as every time they tried to order they got the wrong thing*
- Not taking into account visual impairment

5.4 Discharge to assess – pathway 3

This pathway has the focus of providing care for up to six weeks to allow for an individual's ongoing care needs to be assessed; the way ongoing care is to be funded to be determined; and for that ongoing care to be organised.

During our work it became apparent that there are two different strands to Discharge Assess pathway 3 and that the support individuals received may vary depending on which strand they are within:

1. Coventry and Rugby CCG fund 9 residential and nursing care homes providing a total of 51 beds (see page 10). They also have the ability to purchase a further 49 beds from different homes as needed. For people who are in beds funded by the CCG there is no therapy input in to care funded. Coventry and Rugby CCG officers described these beds in terms of the assessment process for Continuing Healthcare Funding. This is NHS funding

available to people who meet criteria linked to having ongoing healthcare needs, rather than social care needs.

We were informed that on average two pathway 3 placements per month are 'out of area'.

2. Coventry City Council fund 3 care homes to provide 19 pathway 3 beds. The criteria for entering these is that the individual is already known to social care services (received care). People funded by Coventry City Council can receive therapy input from the Council's therapy team.

Sovereign House is one of the Coventry and Rugby CCG funded providers of discharge to assess beds. We spoke to 3 people on the pathway and one senior worker about this specifically in Sovereign House. They are all nursing placements.

Issues highlighted regarding pathway 3:

- Concerns about the standard of information being received about the patient by the care home prior to their discharge from hospital, as this does not always reflect the needs of the person

- Some people are being placed out of area as there isn't local provision to meet their need

- Financial assessments are not always completed within the 6-week period leading to uncertainty and worry for individuals, families and sometimes providers about how beds would be kept available or funded after the 6-week period

- There was not always a bed available for people when they were being discharged from their package

- Correspondence regarding Continuing Healthcare Funding (CHC) decision making was not clear enough in setting out what would happen next both if CHC funding was turned down and if it was accepted eg if a care home bed is required what process is used and where this might be or about the social care assessment process

- Staff thought it would be better if social care were involved in the CHC checklist process to ensure they had information about an individual's needs earlier

- A need for flexibility regarding funding from Health and Social Care was identified by staff. Social Care don't directly take over funding for an individual and this can lead to them moving elsewhere, even if there is a bed available at this home and they want to stay.

5.5 Cross cutting themes & areas for development

a) Positive experiences

Overall the service met the needs of a lot of the people we spoke to. There was evidence of good work happening and many people acknowledging their appreciation for the service they received, as it gave them further time for recovery and regaining their confidence and skills.

b) Multi-disciplinary working

Meetings where the agencies involved in people's reablement packages came together are good ways to make decisions, to support people with their progress through to recovery and wellbeing, as well as starting to develop ways to improve sharing information and managing expectations.

Care home staff benefitted from the multi-disciplinary approach as there was evidence that this was providing a framework for reablement care. However, it was not clear to us how staff providing care in a person's own home and staff within Housing with Care schemes could benefit in the same way.

c) Problem solving and learning

We saw that there was evidence of learning and service development. For example, a manager said that to start with there had been a lot of inappropriate referrals to pathway 2, but now more referrals are appropriate and more identify rehabilitation goals.

Therapy staff said that they had raised that there was a need for more in-depth information at the point of referral and were confident this is being addressed through the input they have given on the therapy transfer form.

d) Communication

Information was not being received in a way that empowered people to be able to understand the process they were going through or possibly supporting realistic expectations of it.

We found that one of the issues around reablement or discharge to assess is the language that is used. It is confusing that the whole programme is called Discharge to Assess and that this contains two reablement pathways and then a pathway 3 which is also called discharge to assess.

In all pathway's individuals were not sufficiently aware/informed of the care they would be getting. Patient folders and goal setting was described but patients in all setting were not sufficiently aware of what these contained.

We identified that a number of different organisations have responsibility for producing written information for patients/families. Despite the effort by different agencies none of this information is accessible, in plain English, or addressing the information needs of patients and family carers.

Individuals need more information about what items they need with them and support to obtain these if they don't have family members. For example in housing with care people need household items.

e) Hospital discharge

Effective discharge into the pathways is very important to be able to meet the needs of individuals. Staff raised concerns about the consistency, quality and detail of the information received from the hospital at the point of referral saying that there might not be enough information about clinical matters or sometimes important information related to equipment needs were missed.

Housing with care staff commented that hospital staff including social workers don't know what Housing with Care is and think it is a care home and this leads to wrong assumptions.

There were issues in terms of the timings of discharge with some being timed late in the day. Availability of medication could also be an issue.

f) The pathways

Providers were concerned that the people being discharged to them were not always on the most appropriate pathway of care e.g. people with dementia or at end of life. How the appropriateness of referrals is monitored so that learning can be made was not clear to us.

We received comments about and could see the pathways operated quite rigidly and that this could make it difficult to address person centred needs as people might not fit in. We did not identify clear routes to move across pathways.

There is a focus in pathway 3 on which funding stream is to be used. The focus should be broader than whether someone qualifies for Continuing Healthcare (CHC) funding as there is an opportunity to improve the health and wellbeing of individuals and with more support and better access to therapy support some may not need so much ongoing care as they could be enables.

The rule in all pathways is that if a person returns to hospital, after 72 hours the process starts again and we spoke to one person who had experienced this.

g) End of life

We asked how end of life care fitted with these pathways and received a number of different responses. Some staff flagged up that people who were at end of the life were on the reablement pathways when they did not think they should be.

Our survey sample for people receiving pathway 1 reablement support in their own home was reduced from approximately 280 to 203 due to the number of people who had passed away.

We are aware that end of life should not stop a person being on a reablement package, as everyone should be entitled to a time of recovery and to gain confidence and skills. However, there is an assessment and operational challenge and potentially a quality of care issue if a person's needs are increasing. The change in circumstances can also lead to difficulties with ongoing funding and assessment of needs.

There are different definitions used by different agencies regarding end of life for example a 6-week period of end of life care and support provided in the last year of life. These must not act as a barrier to appropriate person-centred care.

h) Quality of care

We saw and heard about good quality care but also saw that some people were not getting enough reablement input.

Staff in housing with care schemes seemed under pressure and said it was difficult to fit in the reablement element of their work.

It was not clear if the staff providing home support had enough time to provide reablement support. Some people receiving support in their own home indicated this was rushed and there was tendency for staff to do things for them rather than support them to do tasks.

Recruiting and retaining care staff in care homes is a known issue and if a home was short of staff this impacted on reablement support.

i) Staff training to support reablement

Whilst it was widely recognised that the skills required to support people to regain skills are different to those of caring for an individual the training available to staff did not seem sufficient or consistent. One care home said that there was no additional training for carers supporting people on reablement pathways.

Those working in the community on pathway one providing support at home did not benefit from the same access to occupational and physiotherapists as workers and staff have in care homes.

j) Therapy support

Some individuals and staff felt more therapy input would be beneficial.

Staff in Housing with Care described delays in the first Occupational Therapist visits and we found that 4 people had not seen an Occupational Therapist and had been on the pathway for 2-4 weeks. Important 'Progress Sheets' were therefore also delayed and these should guide the input of the other staff.

There is need to review access to therapy for people on pathway 3 discharge to assess as Coventry City Council funded placements may have this and Coventry and Rugby CCG placements do not.

k) Reablement goals

Most people were unsure or unaware of their support plan or goals. Over 50% relied on their family members to keep up to date information and let them know what was going on through liaising with workers. This would be an issue for those who do not have relatives to do this. Reablement should be person centred and it is important that individuals feel involved in their plan and goals.

l) Equipment

Not having equipment on time was highlighted as an issue by care homes and in Housing with Care. It can lead to delays or difficulties with looking after people safely and effectively.

We also identified an individual who did not have a simple piece of equipment to enable them to carry a drink from their kitchen. No one had picked this up and we were able to get their needs seen.

There was a storage issue when there was a delay in equipment which is no longer needed being collected.

m) Gathering feedback from service users

One of the reasons Healthwatch Coventry undertook this piece of work was that we couldn't see a clear mechanism for people who experience the pathways to feed back.

There is a need to ensure that people have routes to feedback more consistently across the provision and that ultimately patient reported outcomes need to form part of the assessment of the effectiveness of the services and pathways.

Also, almost no individuals knew how to raise a complaint formally.

n) Timeliness in decision making about ongoing care

Transition between different pathways and to new care settings can be difficult for people, especially as one fund comes to an end and there is a need for financial/care assessment for eligibility to different forms of funding.

We received comments in all pathways about issues around the timeliness of decision making about ongoing care. There were suggestions that processes did not help and therefore there should be a review of processes and whether more joined up approaches to assessment across health and social care would be more effective and reduce delay.

o) Measuring outcomes and leadership

We asked in multiple places how outcomes for individuals were identified, recorded, analysed and measured but collated information about the success or otherwise of the reablement pathways was not evident to us.

A suite of information should be available to help develop services at service level and also strategically, because:

- To look at people's outcomes through the pathways can help to support and enable the development of good practice across providers.

- To look at outcomes at a strategic level helps commissioners to see if what they are commissioning is working and what should be commissioned in the future. It will also identify what other conversations need to take place to further develop practice across the range of organisation that are involved.

We saw that reporting lines for this work go upwards through Coventry City Council and Coventry and Rugby CCG as two separate commissioning lines. Therefore, decision making sits within each organisation.

Managers told us that the Joint Commissioning Board has an oversight role and that a joint strategy group had been created with membership from the City Council and Coventry and Rugby CCG. This is positive and there is an opportunity to clarify lines of shared accountability and delegated responsibilities.

6) Conclusion

There is good work to build on to support more people to regain skills and confidence so that people can live independently wherever possible.

At times we found it hard as lay people to understand the pathways, how they worked and if/how they joined together. As we found this difficult, those who use the services are also likely to find it hard to understand the pathways. The information resources and communication described to us do not currently enable people to receive information to empower them.

These pathways were pulled together as a solution for delayed transfers of care from hospital and in some respects bring together different programmes which have existed for some time under one banner. Almost all of our sample had accessed the pathways from hospital.

It is also important to avoid admissions to hospital in the first place and work is being taken forward locally related to this. Therefore, it is time to consider how the discharge to assess pathways can support these pieces of work and how people can access short term support without having to go to A&E or be admitted to hospital.

We heard that individuals do not necessarily fit within the defined approaches the pathways provide. Whilst the intention is for person centred care, we saw pathways that can be too transactional in approach to always achieve this and the reflections we obtained about communication and setting person centred goals highlighted that there is work to do.

Our findings and recommendations can help those responsible for planning joined up approaches such as this to develop them to the next stage.

7) Recommendations

Based on our findings Healthwatch makes the following recommendations to be addressed by providers of care services and therapy services, Coventry City Council and Coventry and Rugby Clinical Commissioning Group.

Communication

1. Improve information and communication with patients by reviewing how the pathways are described and co-ordinating joint work across organisations to produce accessible and user friendly information resources. Involve patients/service users in the design of this and ensure that good practice in plain English and design are used.

   Produce welcome information for people moving into Housing with Care, pathway 2.

Referral at hospital discharge

2. Review referral practice at hospital discharge using input from discharge to assess pathway staff and providers to address issues with quality and flow of information and understanding of the types of accommodation people are being discharged to.

Staff training

3. Address the variation in training of staff by developing a training programme for staff working in different providers to standardise training regarding the reablement element/skills of the work.

Capacity/delivery

4. Address factors including staffing levels/availability, delays in access to therapy input and communication which impact on the available time care staff have to carry out their reablement care role. Care staff who are rushing cannot carry this role out effectively.

5. Address issues with collection of equipment and delays in getting equipment.

6. Address issues highlighted regarding Housing with Care offer: care environment, staff time for reablement support and therapy input delays

Ongoing care decision making

7. Review processes for assessing and agreeing ongoing care needs to improve decision making times to ensure people can move on to future care arrangements when they are ready.

Patient/carer input

8. Further develop the culture of person centred care/support and the involvement of individuals in the development of their goals
9. Develop better ways for patient/user feedback to be routinely collected and used as part of quality processes. Create a programme of work to introduce patient/family carer reported outcomes.

Strategic Accountability

10. Clarify lines of joint accountability and joint strategy across health and social care regarding all discharge to assess work/pathways.

Tracking outcomes

11. Develop the ways in which outcomes for individuals and the pathways are tracked to inform decisions relating to effectiveness and service development.

    Undertake co-ordinated work to identify outcomes tracking measures/processes across City Council and CRCCG

    Establish a clear feedback route to care homes, housing with care and home support care providers' for information about the outcomes for the people they have cared for so that they can see success and learn.

12. Produce transparent outcomes data which can be used in other health and social care system discussions. This should cover:

    - How many people return home or go on to other care settings
    - Readmission to hospital rates – specifically for people entering pathways 1,2 and 3 from hospital
    - Length of time people actually spent in discharge to assess funded beds/home support

Review

13. Review the programme to see where a more flexible and person centred approach can be introduced to pathways. Included a review of:

    - access to therapy provision in all pathways and consider how therapy provision can be more equitable in pathway 3
    - where the needs of people approaching end of life are best met and what part these pathways should play.

14. Look at "step-up and "step down" support for individuals by linking to reablement pathways to support the aim of reducing admissions to hospital. Individuals who become unwell will benefit from direct access to such support from the community.

8) Response

We met with managers from Coventry City Council and Coventry and Rugby Clinical Commissioning Group to discuss our findings. The following action plan was Co-ordinated across Coventry City Council and Coventry and Rugby CCG by Jon Reading the Chair of a Joint Strategy Group. We continue to have conversations about actions and mechanisms to take work forward.

Healthwatch recommendation	Agreed Actions in response to Healthwatch recommendations	Owner	Review date
1. Communication	a. Document what written information is available for patients and families in respect of D2A pathways b. Review communication material to ensure it is written in user friendly way c. Review information to ensure that people are clear about what items they need to supply when accessing housing with care for a short period d. Ensure the distribution of information about short term housing with care to hospital staff e. Review communications material in relation to "End of Life Care"	Kerrie Manning	August 2019
2. Improve personalised approaches	a. Ensure appropriate therapist input for people discharged via pathway 3	Jon Reading/Marie West	July 2019

Healthwatch recommendation	Agreed Actions in response to Healthwatch recommendations	Owner	Review date
	b. Develop pathway 3 at home option to ensure a home based offer in addition to residential and nursing	Tracey Rabin/Rae Bottrill /Jason Bejai	July 2019
3. Quality of Reablement	a. Review and ensure appropriate training of care staff in reablement approaches b. Review and recommission pathway 2 care home and housing with care provision. c. Consider focusing Housing with Care reablement in fewer facilities d. Optimise use of dedicated staff teams for reablement	Jason Bejai/Cathi Sacco Cathi Sacco/Lisa Taylor Cathi Sacco Jason Bejai	October 2019 March 2020 March 2020 July 2019
4. Therapy support.	a. Complete Therapy review and implement arrangements	Marie West/Jon Reading	November 2019
5. Quality of service delivery	a. Run developmental sessions for providers to: • Explore good practice and support peer to peer learning e.g. regarding organising care, communicating with service users and other suggestions highlighted in this report. • Jointly address/discuss sector issues e.g. recruitment and retention etc. • Share knowledge on legislative changes or changes in service requirements	Jason Bejai Cathi Sacco Jeanette Hudson	Ongoing

9) Acknowledgements

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Healthwatch Coventry
27-29 Trinity Street
Coventry
CV1 1FJ
024 7622 0381
Email: healthwatch@vacoventry.org.uk
www.healhwatchcoventry.co.uk

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Voluntary Action Coventry