Leaving hospital: experiences of those needing reablement support at home or intermediate care

healthwatch Kirklees

healthwatch Calderdale

About Healthwatch

Healthwatch Kirklees and Healthwatch Calderdale are your local health and social care champions. We are part of a network of over 150 local Healthwatch across the country.

We're here to listen to the issues that really matter to people in Kirklees and Calderdale and to hear about your experiences of using local health and social care services. We're entirely independent and impartial, and anything you share with us is confidential.

Healthwatch uses your feedback to better understand the challenges facing the NHS and other care providers and we make sure your experiences improve health and care for everyone – locally and nationally. We can also help you to get the information and advice you need to make the right decisions for you and to get the support you deserve.

Contents

Summary

Discharge planning in hospital

Patients reported the following issues:

- Not feeling involved in discharge planning.
- Being discharged to a place that didn't meet their needs.
- Not feeling ready to leave hospital.
- Feeling of a chaotic, mismanaged, poorly communicated discharge, resulting in errors and oversight.
- Lack of information about the service being discharged.
- Not being given written information about who to contact if they needed further advice or support.

Patients largely praised the care and treatment they received in hospitals but noted the strain on staff due to the busy environment and excessive demands.

Intermediate care settings

Patients reported:

- Plenty of praise for the care and support being offered in intermediate care settings. Staff interactions with patients were friendly and respectful.
- The quality of physiotherapy was highlighted as positive.
- There were concerns about the number of staff in all settings, with patients feeling the staff were over-stretched and that this impacted the quality of care.
- Patients appreciated having their own rooms with en-suite facilities.
- Patients wanted more opportunities to engage in activities and to connect with other people.
- Patients wanted clearer information on how long their stay was likely to be.

Reablement at home

The majority of people receiving reablement felt the care they received has helped them to be independent.

There was praise for the quality of care, skill, and kindness of staff but there were numerous suggestions for how the service could be improved, including:

- Providing reablement for longer, or providing a more flexible package of care.
- Providing reablement in a timely way, not relying on family to bridge the gap until the service is available.

Overall

There is inequality of access to reablement and intermediate care beds for ethnically diverse people. Healthwatch are undertaking an additional piece of engagement to understand the reason for this.

Recommendations

Hospital discharge planning

- **Enhance patient and carer involvement:** develop and implement policies to ensure that patients are actively involved in their discharge planning. This includes regular meetings with healthcare teams to discuss their discharge plans, preferences, timescales, and concerns.

- **Ensure suitability of discharge destinations:** conduct thorough assessments to ensure that discharge destinations meet the specific needs of patients.

- **Improve readiness for discharge:** Establish protocols to assess patients' readiness for discharge, ensuring they feel prepared and well enough to leave the hospital.

- **Streamline discharge processes:** develop and implement a structured discharge planning process that is well-communicated and avoids being rushed, minimising the risk of errors and oversights.

- **Provide comprehensive information:** ensure that patients receive detailed information about the services they are being discharged to, and include written contact information for further advice or support post-discharge.

Intermediate care settings

- **Promote social interaction and activities:** introduce and facilitate opportunities for social interaction, activities, and outdoor access to combat feelings of loneliness, isolation, and disconnection, and to support overall physical and mental health. This offer could be established or enhanced by involving volunteers.

- **Offer explanations:** Provide clarity to patients about what they can expect from their stay in intermediate care and how long their stay is likely to be.

Reablement at home

- **Extend duration and flexibility:** consider extending the duration of reablement services and offering more flexible care packages to better meet individual patient needs and support long-term independence.

- **Ensure timely provision:** implement measures to provide reablement services promptly, reducing the reliance on family members to bridge the gap until services are available.

Equity

- **Address inequities in access:** work with Healthwatch to conduct thorough research to understand the barriers faced by ethnically diverse people in accessing reablement and intermediate care beds. Develop and implement strategies to ensure equitable access to these services for all patients.

General recommendations

- **Strengthen communication:** across all settings, improve communication between healthcare providers, patients, and their families to ensure clarity and understanding of care plans and available support services.

- **Monitor and evaluate outcomes:** implement robust monitoring and evaluation systems to track the effectiveness of the improvements and ensure that patient outcomes and experiences are continually enhanced.

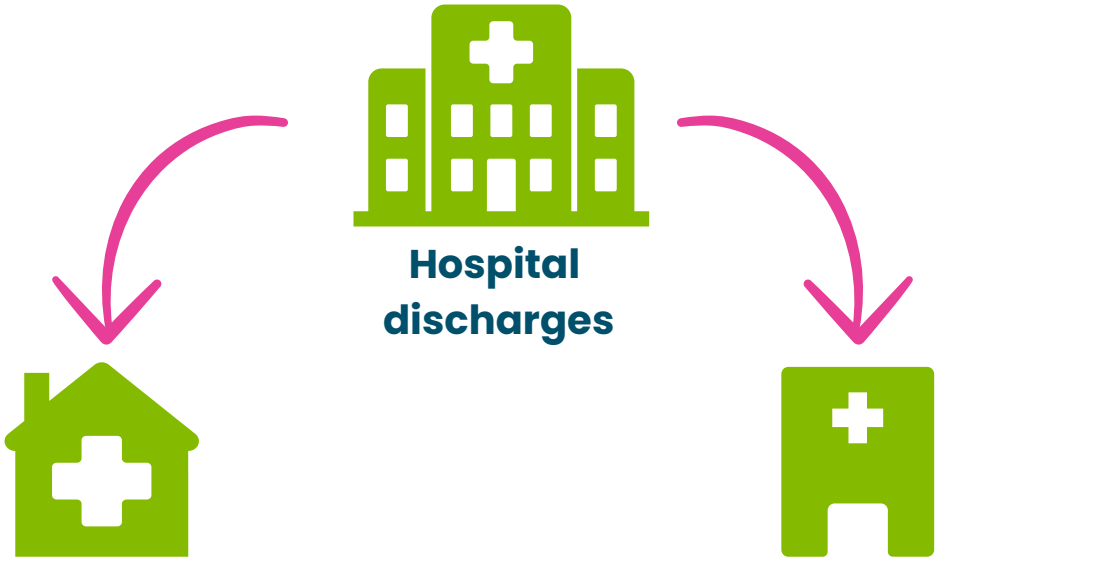
By addressing these recommendations, health and social care providers can significantly improve the discharge planning process, intermediate care settings, and reablement at home services, leading to better patient outcomes and experiences.

Introduction

Hospital discharge is a common topic in the feedback Healthwatch receives. Our data shows that some people struggle when they are discharged without enough support, which can slow their recovery and increase the risk of being readmitted.

Our partners have created plans to improve the discharge process, so more people will go home with reablement support, making 'home' the usual place people go after leaving the hospital. Reablement is a short, intensive service, provided in the home, which is offered to people who have the potential to recover or improve their level of independence.

Some people who need more recovery time and extra support will go to an intermediate care setting after discharge. Intermediate care provides people with 24-hour support and care from a team of staff based in an intermediate care setting where therapists support people to become more independent and carry out day to day activities.



Healthwatch wanted to learn about people's experiences with both of these discharge pathways.

Please note that there are other ways for hospital discharge but this engagement was only looking at people's experience of pathways 1 and 2.

People were asked about the discharge process in hospital, for example, did they feel involved in conversations and decisions about their discharge plan and were they given information about the service they were being discharged to? People were also asked what they thought about the care they received from the reablement service or from an intermediate care setting, in both Kirklees and Calderdale.

What we did to gather feedback

From 19 February – 19 April 2024, the following engagement took place:

- Visits to Intermediate Care settings to speak directly to patients receiving care there. We visited Moorlands Grange in Huddersfield twice, Ings Grove in Mirfield three times, Oak Unit in Halifax twice and Valley View in Halifax once.
- Phone conversations with people receiving reablement support in their homes (or we spoke to their relatives).
- Information about our engagement was shared on our social media so that people could share their views with us.

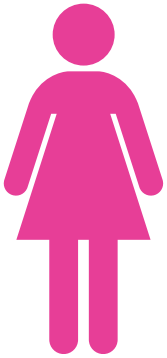
A survey was used to ask questions and record responses for all the above engagement.

We recorded case studies for a few people who told us about their experience in more detail.

Our engagement was targeted only at people who had been discharged with reablement support in place or to an intermediate care setting. We spoke to people who were receiving this type of care, or to their relatives.

Demographics

112 people completed the survey. Not everyone answered the demographic questions, but for those who did, we have the following details:



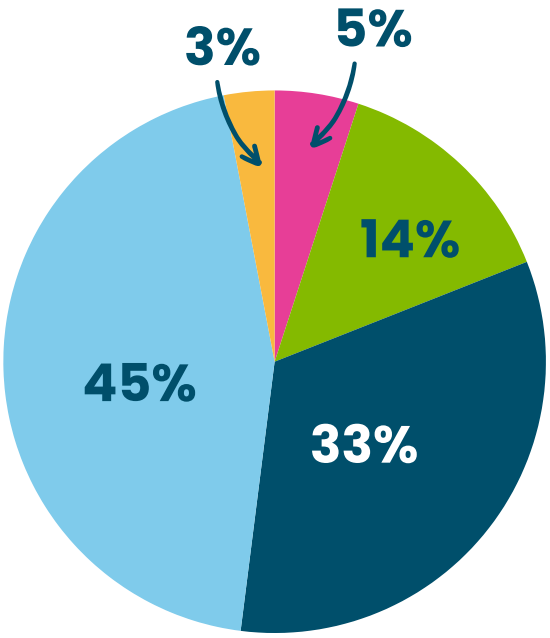
67% were female

33% were male

All having the same gender identity as sex recorded at birth, apart from 2 respondents who preferred not to say.

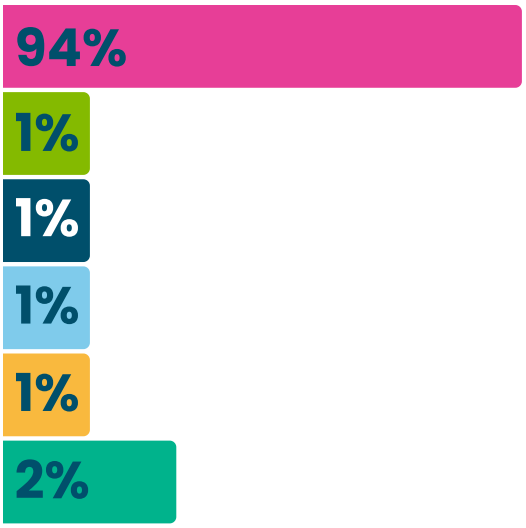
Ages

- **5%** of respondents were aged between 24 and 49.
- **14%** were aged between 50 and 64.
- **33%** were aged between 65 and 79.
- **45%** were aged 80 and over.
- **3%** preferred not to say their age.



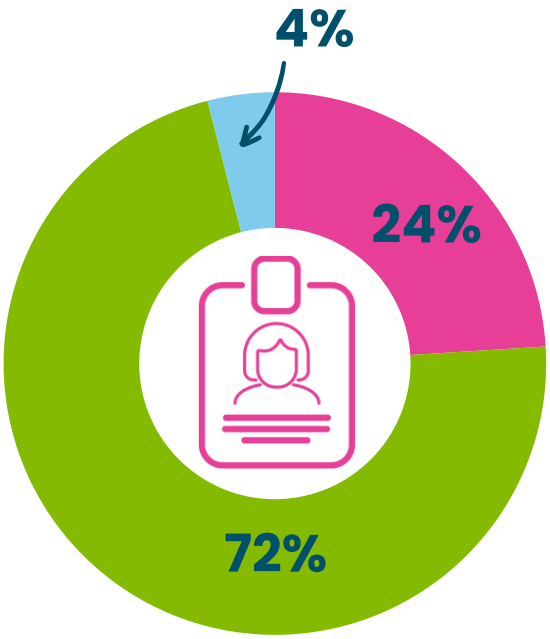
Ethnicity

- **94%** of respondents identified as White British.
- **1%** identified as Mixed/Multiple Ethnic Group: Asian and White.
- **1%** identified as White Irish.
- **1%** identified as White from any other White background.
- **1%** identified as other.
- **2%** preferred not to say their ethnicity.



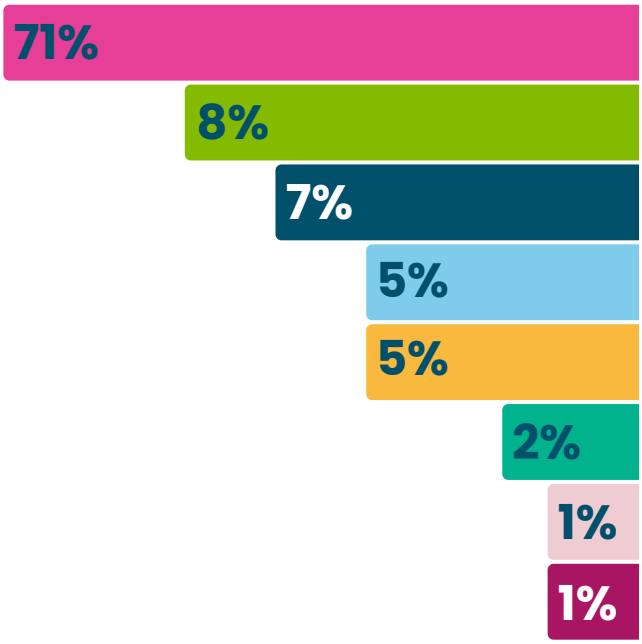
Carers

- **24%** of respondents identified as a carer.
- **72%** did not identify as a carer.
- **4%** preferred not to say.



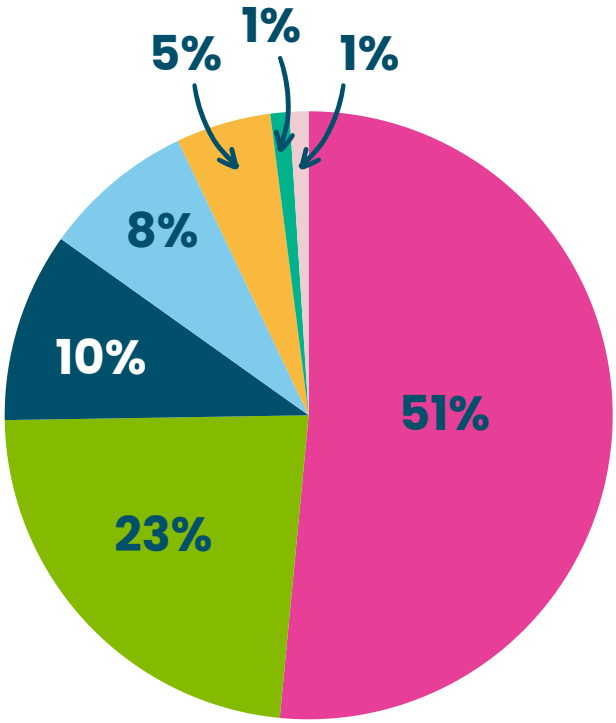
Current (main) employment status (respondents could select more than 1 option)

- **71%** of respondents said they were retired.
- **8%** said they were unemployed andunable to work.
- **7%** said they were working full-time.
- **5%** said they were working part-time.
- **5%** said they were a carer.
- **2%** said other.
- **1%** said they were unemployed and looking for work.
- **1%** preferred not to say their employment status.

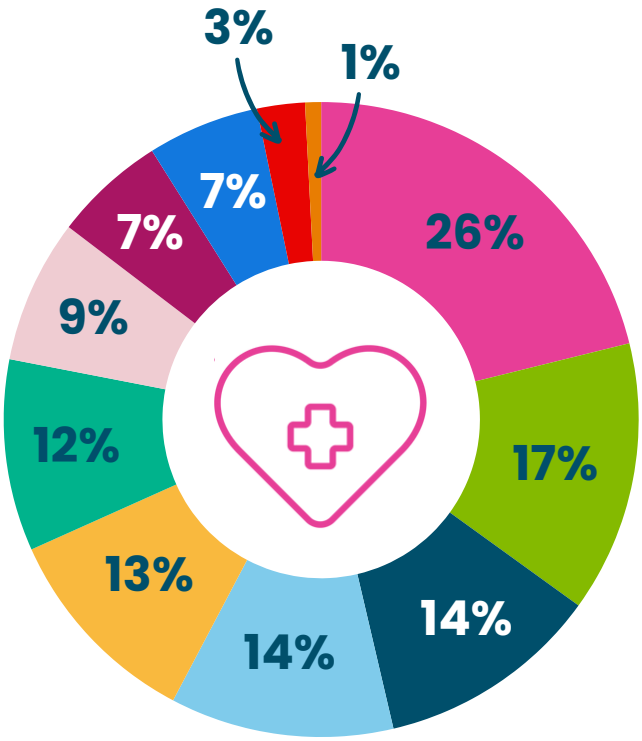


Disability (respondents could select more than 1 option)

- **51%** of respondents stated that they had a physical/mobility disability.
- **23%** stated that they did not have a disability.
- **10%** stated that they had a long-term condition.
- **8%** stated that they had a sensory disability.
- **5%** stated that they had other.
- **1%** stated that they had a learning disability.
- **1%** stated that they had a mental health disability.
- **1%** preferred not to state if they had a disability or not.



Long-term condition (respondents could select more than 1 option)



- **26%** of respondents said they had other long-term conditions.
- **17%** said they had asthma, Chronic Obstructive Pulmonary Disease (COPD), or a respiratory condition.
- **14%** said they had hypertension.
- **14%** said they had a musculoskeletal condition.
- **13%** said they had a cardiovascular condition.
- **12%** said they had diabetes.
- **9%** said they had a mental health condition.
- **7%** said they had blindness or a severe visual impairment.
- **7%** said they had cancer.
- **3%** said they had chronic kidney disease.
- **1%** preferred not to say if they had a long-term condition.

Finances

- **35%** had **MORE THAN** enough money for basic necessities and **A LITTLE** spare that could be saved or spent on extras and leisure.
- **27%** preferred not to stated their finances.
- **21%** had **JUST ENOUGH** money for basic necessities and little else.
- **9% DID NOT HAVE ENOUGH** money for basic necessities and sometime or often ran out of money.
- **8%** had **MORE THAN** enough money for basic necessities and **A LOT** spare that could be saved or spent on extras and leisure.

Other

- **20%** said they lived in a rural/isolated area.
- **8%** said they did not have a support network.
- **3%** had experienced domestic abuse.
- **2%** were neurodiverse.
- **2%** were veterans.
- **2%** were homeless.

Places of residence

Responses were received from people living in every postcode area of Kirklees and Calderdale.

Findings

Section 1 presents people's experience when planning for their discharge from hospitals at Calderdale & Huddersfield NHS Foundation Trust and at Mid Yorkshire Teaching NHS Trust.

Section 2 and **Section 3** cover the experiences of reablement or care in intermediate care settings in both Kirklees and Calderdale.

Section 4 highlights some carer-specific feedback.

Section 5 comments on health inequalities.

Section 6 sets out how Age UK's Home from Hospital Service, in partnership with Community Transport, supports people to safely return home following a stay in hospital.

Section 1 - Planning for discharge

Huddersfield Royal Infirmary

50 respondents were discharged from Huddersfield Royal Infirmary (HRI). 64% of the respondents were patients, and 36% were relatives of patients, usually their main carer. Demographics can be seen in Appendix 1.

Less than half of all respondents felt they'd been involved in the discharge planning process and just over half felt the discharge plan met their needs.

Numerous discharge-related issues were mentioned, including:

- **Lack of consultation and communication:** patients and relatives often felt excluded from the discharge process, with little to no consultation or explanation of the plan.

> ***"One minute she was going to one place for rehabilitation then suddenly she was told she was just going straight home. Lack of communication between the ward and our family. Things weren't ready at home."***
> Female, Kirklees, age 80+, home reablement discharge.

> ***"I never saw a discharge plan. The doctor came and gave medication and leaflets in a carrier bag, told me about side effects. The staff at Moorlands took the carrier bag with the information in. No one explained to me about my discharge."*** Male, Kirklees, age 65-79, Intermediate care discharge.

- **Discharge destination not meeting the person's needs:** some felt the place they were discharged to was unsuitable for their rehabilitation, lacking the necessary resources to support their recovery.

> ***"I stayed at Astley Grove for 4 weeks with minimal input from physio. My physical and mental health deteriorated greatly in this time. Because they were short-staffed I spent most of my days in the same chair and was put to bed for the night at 6:30pm every evening. I developed a DVT in my left leg and was no closer to recovering from my injury."***
> Female, Kirklees, age 80+, intermediate care discharge.

> ***"I was sent to Lydgate Lodge care home first before they moved me to Ings Grove. I was medically ready to leave the hospital but there was no room for me at Ings Grove so I was taken there but it was not appropriate. I didn't see a physio the whole 2 weeks I was there so made no improvement whatsoever and felt hopeless and like I would never recover."***
> Female, Kirklees, age 80+, intermediate care discharge.

- **Premature discharge:** a third of respondents felt that they were not ready to leave hospital when they were discharged. Concerns included:
  - **Medical readiness:** several patients felt medically unfit to leave the hospital. For example, one patient experienced ongoing symptoms and required frequent hospital visits after discharge.

> ***"I was glad to be going home to have my own space but I didn't really feel well enough to be leaving if I'm honest and have since been back and forth to the hospital with a DVT."***
> Female, Calderdale, age 80+, reablement discharge.

  - **Mobility issues:** some felt concerned about ongoing mobility issues, such as difficulty managing steps or experiencing pain.

> ***"I was fed up in there [Hudderfield Royal Infirmary] but still couldn't manage steps. I knew my bed was moving downstairs but there are steps into my house so I felt I would be housebound."***
> Female, Calderdale, age 65-79, reablement discharge.

- **Rushed discharge:** although 64% of respondents said they felt ready to leave when they were discharged, some felt their discharge was not timely or well planned, leaving them feel unprepared and rushed. In some cases, patients felt pressured by staff to free up hospital beds.

"I felt It was an abrupt discharge, I didn't feel it had been discussed sufficiently and I didn't feel fully ready to leave hospital and I didn't feel fully ready to be sent home."
Female, Kirklees, age 80+, reablement discharge.

"I was told by the social worker at the hospital that there was a bed for me at the rehabilitation home, Astley Grange. However, I knew this was a nursing home and not rehabilitation, when I questioned this with the social worker she told me 'well we really need your bed' and 'you have until 5pm to decide between going there or discharging yourself home', neither I felt were appropriate."
Female, Kirklees, age 80+, Intermediate care discharge.

- **Lack of support at home:** Some patients returned home without the necessary support in place, resulting in difficult situation where family members had to provide care.

"I felt It was an abrupt discharge, I didn't feel it had been discussed sufficiently and I didn't feel fully ready to leave hospital and I didn't feel fully ready to be sent home."
Female, Kirklees, age 80+, reablement discharge.

- **Information about services:** just 52% of respondents said they had been provided information on the service to which they were being discharged to, the remaining 48% of all residents said they were not give, or were unsure if they'd been given, information about the service they were being discharged to.

  One individual told us how the lack of information had caused her family a lot of anxiety.

"Lack of communication of when I would be leaving and where I would be going until the last minute. The longer I went on not knowing the more anxious I got... until the day before they discharged me and brought me here I didn't even know it was an option, it would have saved me and my family a lot of worry to know sooner."
Female, Kirklees, age 50-64, Intermediate care discharge.

Similarly, another individual had been provided with very little detail as to what care to expect post-discharge.

"They had told me as I was leaving the hospital I would be having carers at home but I didn't have much more details than that and my wife had been told nothing. We just had to wait to see if anyone showed up, but thankfully they came that evening to get me settled in bed."
Male, Calderdale, age 80+, reablement discharge.

- **Written information:** two thirds of patients hadn't been given, or didn't know if they'd been given, written info about who to contact if they needed further advice or support after leaving the hospital.

- **Errors with or delays in organising essential medication, equipment, or transport:** several patients reported issues with these necessities not being arranged in a timely or organised way.

"Mix up over medication in hospital, discharge medication missing on discharge and taxi brought it home, but ended up with more antibiotic than needed. Initial assessor made a mistake and asked for the wrong care alert bracelet."
Male, Kirklees, age 80+, reablement discharge.

"We got the transport home but didn't have any pain medication which all had to be arranged the next day. We were called next day by a nurse who was very apologetic and then we managed to get the medication sorted after a day or two. But when told you can get the transport now or you may have a long wait you just go with it, this all happened over the weekend so it all threw us into panic mode. Didn't get a discharge letter until 3 or 4 days later."
Male, age and location not provided, reablement discharge.

"I had to arrange delivery of incontinence pads for myself. This wasn't provided by the hospital before discharge and the nurses said they couldn't do anything about it so I had to ring round various different places and eventually find an organisation in Bradford who would supply me with what I needed."
Male, Calderdale, age 80+.

One patient described the process as 'chaotic' as an error in booking their transport delayed their discharge and similar delays were experienced by others who were waiting for medication.

> ***"The day I was due to leave hospital was very chaotic. ….I was waiting on the ward for hours and hours. By the evening I had still not gone anywhere and they eventually came to tell me that hospital transport had not been booked for me and so I wouldn't be going until the following day after all. It could have been a lot less stressful than it was."***
> Female, Calderdale, age 80+, reablement discharge.

> ***"I was discharged to the discharge lounge and left there waiting for a very long time as they didn't have the medication ready and then when it came some was missing and so had to wait even longer."***
> Female, Kirklees, age 80+, reablement discharge.

- **Issues with medical records:** we were told about instances of medical oversight and lack of follow up care, such as not recording conditions and failing to notify the GP of the patient's health, leaving patients and their loved ones feeling abandoned and unsupported in their recovery.

> ***"Discharged with a UTI which was not recorded on discharge notes and GP not notified. Information on discharge notes was also incorrect, treatment and medication information not accurate and incorrect."***
> Female, Kirklees, age 65-79, reablement discharge.

- **Discharge in unsuitable clothing:** one patient and one relative shared their concerns of being discharged and sent home on hospital transport, whilst still wearing their pyjamas during the winter months.

> ***"I was discharged from the discharge lounge at HRI, I was there for about 1 and half hours waiting for hospital transport. I was sent home wearing my hospital gown and a thin blanket and it was a particularly cold January day. I was frozen to the bone by the time hospital transport got me home. My wife had not been told I was coming home but thankfully had not been out when I arrived, she was very concerned and disgusted with the state of which I was sent home."***
> Male, Calderdale, no age provided, reablement discharge.

"He came home via an ambulance in hospital pyjamas in the middle of winter and with a catheter that he pulled out before we got to see him he has mixed dementia."
Female, Kirklees, age 50-64, reablement discharge.

- **Long waiting times for discharge:** other shared their experience of waiting long periods of time to be discharged.

"It was a late discharge about 6pm and sat in waiting quite a long time before someone came to take me home, I was offered food and drink, everyone was helpful and nurses kept coming to say it had been organised but the service seems very, very busy."
Female, Kirklees, age 65-79, reablement discharge.

"Hospital said medically fit for discharge but it took 5 days to happen."
(demographics unknown).

Calderdale Royal Hospital

21 respondents were discharged from Calderdale Royal Hospital (CRH). 76% of these were patients, 24% were relatives of patients, usually their primary carer. Demographics can be seen in Appendix 1.

Only half of respondents felt they'd been involved in the discharge planning process and just half felt the discharge plan met their needs.

Numerous discharge-related challenges were mentioned, including:

- **Timeliness of discharge:** just over half of respondents felt ready to leave hospital when they were discharged but comments reflect that patients often felt the discharge was badly timed and that this put significant pressure on them and their families.

  One patient felt that the discharge plan was rushed and that they weren't adequately prepared to handle the challenges of their home environment post-discharge.

"It felt rushed, I wasn't ready to tackle the home environment."
Female, Calderdale, age 65-79, reablement discharge.

Another patient told us they were discharged before they were ready and without support which led to them being readmitted. They were then given reablement support but they felt the initial rushed discharge had prolonged their recovery.

"I am grateful for the support I am getting from the reablement team now and just wish I would have had it the first time as they would have been able to see my deterioration sooner and possibly stop me needing to be readmitted."
Female, Kirklees, age 65-79.

Three patients told us they didn't feel well enough or physically able enough to be discarded when they were, and they worried about getting more unwell or falling unwell. For one individual this led to readmission.

"I was sent home when I think I wasn't ready to be and without a care package and I became very ill. I was readmitted."
Female, Kirklees, age 65-79, reablement dishcarge.

One relative didn't personally feel the patient was well enough to leave the hospital and a short time later they had to return to the hospital for an extended stay before being truly ready for discharge.

"He was originally in hospital the first time tues - sat and he was still poorly when discharged and ended up going back into hospital."
Female, Kirklees, age 65-79, reablement discharge.

One patient shared that he was told his hospital bed was needed despite his care back at home not being able to start.

"I was told I was medically fit to leave the hospital but the care package for when I moved back home wasn't ready to start. They asked if I could go stay with a family member first and made arrangements for me to move into my son's and for him to take care of me for a week before the care was ready to start in my own home. I was very apprehensive about this and would have preferred to stay in the hospital but I was told my bed was needed."
Male, Calderdale, age 80+, reablement discharge.

- **Poor communication and coordination:** patients reported receiving mixed messages and poor communication from professionals.

> ***"The discharge co-ordinator said one thing, the consultant said another and nothing was communicated to us. The communication was atrocious."***
> Male, Kirklees, age 50 – 64, reablement discharge.

Patients stressed how communication with hospital staff is key during discharge. They frequently felt like they had to push to get the info they needed. A relative described a lack of communication regarding the discharge, leading to confusion and stress for both the patient and themselves.

"I had to fight for information and it took two days before he did come home. This was not good as it left us feeling very stressed about this. I had to really push for them to get it sorted. Communication needs really improve and let people know what is going on to prevent them getting upset."
Female, Kirklees, age 65- 79, reablement discharge.

"Communication is the major thing and transparency between doctors/ consultants as they all have different opinions and need to communicate with discharge coordinator and matron on wards. I had to be pushy to get the information."
Male, Kirklees, age 50 -64, reablement discharge.

Some were told they could go home, only to be left waiting without updates.

> ***"I was told [I] was able to go home, raised [my] hopes and then didn't communicate why we were still left there."***
> Male, Kirklees, age 50 -64, reablement discharge.

Communication around mediation was very confusing for a carer who shared their experience.

"She was discharged with 2 weeks worth of medication and I was told to throw away her prescription and that a new one would be sent to her GP for her ongoing medication. I phoned the GP after 1 week but they had not received anything from the hospital and so I had to chase it up with the hospital which took lots of calls back and forth. She eventually got her prescription on the last day of the medication she had been given from the hospital so thankfully she didn't have to go without but it was close."
(discharge home with reablement from Calderdale Hospital).

- **Discharge destination not meeting the person's needs:** one relative shared her father's experience of virtual ward discharge at home and she felt this was not done with his best intentions but as a means to free up bed space in hospital.

- **Information about discharge destination:** only just over half of all respondents said they were given information about the service they were being discharged to.

  One patient told us how the lack of information she had been given about where she was being moved to had caused unnecessary anxiety.

"When I left CRH I was expecting to go to HRI (I have been there before I much preferred it to CRH) so when I found out I was not going to HRI and going to Ings Grove instead I was very anxious as I didn't know anything about it and I was scared what it would be like. I have been pleasantly surprised with the Ings Grove."
Female, Kirklees, age 80+, Intermediate care discharge.

Dewsbury & District Hospital

13 patients were discharged from Dewsbury Hospital. Demographics can be seen in Appendix 1.

The main themes were:

- **Involvement in discharge planning:** just over half of all patients said they were not involved in the discharge plan, but almost all respondents said discharge plan met their needs.

"Discharged from Dewsbury Hospital everything was fine not involved in plans for hospital discharge but it met my needs."
Male, Kirklees.

"Being more involved instead of being told and asked if I was ready to be discharged rather than that I would be discharged. Being more involved in the decision and process. Seeing discharge information and explaining it to me."
Male, Kirklees.

"Originally discharged from Pinderfields to Dewsbury but I thought I was going home. Couldn't understand why I was moved from there to Dewsbury."
Male, age 65-79, Kirklees .

- **Timeliness of discharge:** almost all patients felt ready to leave hospital when they were discharged but some comments reflect issues with the discharge feeling rushed and not well planned.

"All done very quickly. Discharged from Pinderfields but thought I was going home."
Male, age 65-79. Kirklees.

"The communication between the hospital and care team at point of discharge. Care team needs more notice of discharge to arrange carers to be at the house or if family needs to be home to receive the person coming home they need more notice. I was given 2 hours' notice she was coming home and could not leave work."
Kirklees Carer, Female, age 80+.

"I was only told about my discharge on the day I was leaving hospital. They got me up and out of bed at 8am and told me I would be going home so I called my daughter who lives in Nottingham. Then at 9:30am they said the care wasn't ready so I would not be leaving today. Then they moved me to another ward and I wasn't sure why. Only later found out after being there for a couple of hours that I was on the discharge ward and was going home that day so rang my daughter again to let her know things had changed again but I wasn't actually discharged until 7pm that evening. I was exhausted by the uncertainty of it all and things could have gone smoother."
Female, Kirklees, age 80+.

"Discharged 1st time with a suspected chest infection and readmitted 5 days later concerned for breathing, had low oxygen levels on admittance. I felt she was not ready to leave then and told them this but my concerns were ignored. 2nd time discharged I wanted her to go to Ings Grove, but was told she could cope with care at home. She fell twice in 3 days, thankfully she was not injured but the risk was there."
Kirklees, Carer, Female, age 80+.

- **Information about discharge destination:** only half of respondents said someone explained what to expect from the service they were being discharge to and how it may help. Most said they were given written information about who they could contact if they needed further information or advice once they'd been discharged.

> ***"There was only one discussion about location and I would have preferred somewhere closer to home so family could visit to bring necessities but had to take this offer as there was no option in the end."***
> Male, age 65-79 Kirklees.

Pinderfields Hospital

We heard from 9 patients discharged from Pinderfields Hospital. Demographics can be seen in Appendix 1.

The main themes were:

- **Involvement in discharge planning:** just over half of patients who responded said they were involved in their plan for discharge and almost all respondents said the discharge plan met their needs.

- **Timeliness of discharge:** almost all respondents felt ready to leave hopsital.

"I think I was in hospital 2-3 days longer than necessary so the fact that I was able to come home and be supported by the home first team made a big difference to my recovery from the onset."
Male, Kirklees, age 65-79.

"I was grateful to be to have the care in place to recover at home as I would not have liked to be in hospital all this time."
Male, age 65-79, Kirklees.

- **Information about discharge destination:** most patients said that someone had provided information about the service they were being discharged to and how this may help them.

- **Experience in the discharge lounge:** one carer told us in detail about their negative experience of accompanying their relative in the discharge lounge.

"The person I care for was placed in the discharge lounge, it was awful, the disorganisation of the place, It wasn't discussed and I was just told they were in the dispatch area when I went to visit, it was chaotic…temperature in the room was cold and are sat waiting for a long period with uncomfortable seats and they were sat in their bedclothes, cold, I had to fetch a blanket, we had to wait many hours as we were waiting for medicines and discharge letter and they won't arrange transport until they have them so you can be waiting even longer. You should not have to leave the ward until the discharge paperwork and medicine is all done and then you can sit in the discharge lounge, reducing the time you wait. People were sat waiting even longer than we were, it is atrocious to treat people like this I was aching and I am a reasonably fit person but to have someone recovering from an illness and having to wait is unacceptable. Staff came to offer drinks and snack but they were not really appropriate for the person I care for and you just want to go home."
(discharge home with reablement from Pinderfields Hospital).

Pontefract Hospital

We had no survey responses about discharge from Pontefract Hospital. However, we heard from someone who wanted to share their experience in detail:

Carol* felt she would benefit from having support at home after leaving hospital but, even when she asked, she wasn't offered anything…

"I was discharged from Pontefract Hospital without any support from the reablement team."

"I was offered no support at all"

"At my pre-op no one mentioned steps or offered support from the reablement team even though I spoke about it to them, they didn't ask if I could manage by myself at home even though I told them I live alone."

"I felt fobbed off "

"The day before I was discharged I was asked if I felt ready to go home, I said I would be ready to go home tomorrow but will need hospital transport. I did not see a consultant after my operation but I did see a practice nurse and the care assistants were all very good…

*not real name

...On the day of discharge, I got a pack with my discharge letter and to say what first day of physio would be, meds, dressings, nothing was discussed or explained. The discharge letter also had the wrong information on, it had guidance for a hip operation but I had knee surgery. I had to go through the whole pack reading it when I got home. I was transferred from hospital bed not the patient discharge lounge I had all my clothes with me and got dressed myself, "there was no one around when I was taken by hospital transport service home, no one said goodbye."

Section 2 - Care received in intermediate care settings

Ings Grove House, Mirfield

Description of service:

Ings Grove House is an intermediate care setting that supports up to 40 patients. Its purpose is to support hospital discharge and reduce the risk of hospital readmissions through rehabilitation, helping individuals regain their independence before going home. Kirklees Council manages Ings Grove House to provide short-term rehabilitation support in partnership with Locala's Intermediate Care Team which is based on site.

Patients are cared for by a team including care staff, Locala nurses, physiotherapists, occupational therapists, and rehabilitation assistants. A visiting GP, pharmacist, and pharmacy technicians are available as needed.

Discharge planning begins upon admission, with ongoing needs identified and plans made to introduce any services or equipment required for discharge. Patients are encouraged to take part in activities to aid their rehabilitation including physiotherapy and mobility practice and following the advice and techniques taught by the therapists. Patients are encouraged to do as much as they can themselves to promote recovery and independence.

Each patient has a private room with en-suite facilities, TV, mini fridge, wardrobe, drawer space, personal telephone, and WIFI. There is a call system in place in each room for assistance.

Overview of our visit:
We visited Ings Grove House three times and engaged with 18 patients in total. Demographics can be seen in Appendix 1.

The facility was at or near full capacity during our visit. Staff were welcoming on both occasions.

Key themes from our engagement at Ings Grove House:

- Patients appreciated the caring and positive attitudes of staff but noted concerns about staff shortages leading to feelings of being rushed and some needs not being met promptly.
- Physiotherapy was particularly praised for its positive impact on patients' confidence, independence, and recovery.
- There was a lack of communication regarding the expected length of stay and recovery time.
- Limited opportunities for social engagement and outdoor activities were noted.

The care provided at Ings Grove House:
We asked patients to rate the care they received at Ings Grove House and the average was 4.4 out of a possible 5.

Intermediate care is a service provided for up to 4 weeks but a number of patients we spoke with told us they had been there well beyond this period due to their complex recovery.

Environment:
The overall environment was calm and welcoming. Corridors were clutter-free and well-signposted. The rooms were spacious, well-lit, and had pleasant views. Many patients decorated their rooms with personal items, enhancing their sense of ownership and privacy after hospital stays.

Ings Grove House has a dining area, communal room, conservatory and kitchenette which we were told patients and visitors are all able to access. The communal area and conservatory are nice and bright with good spaces for activities or to promote socialising, but we did not observe them being used on any of our visits; we did however witness both these spaces being used as meeting rooms for staff.

On our first visit, we were told by a member of the nursing team that patients were encouraged to only access the communal areas with the assistance of staff as, for their own safety, they didn't like them to walk down the corridor unassisted. This is an extra pressure on staff and a possible reason why the areas appear to be underused.

Similarly, although we were told by staff that they encourage patients to enjoy their meals within the main dining rooms, as this promotes conversations and healthy interactions with the other patients, only one individual we spoke to mentioned eating in the main dining room on one occasion and since then he had been brought his meals to his room. Several other patients told us they ate their meals in their own rooms.

A number of patients commented on the lack of interaction with other patients regularly, outside of group therapy sessions.

> ***"Group exercise class is good, get to meet people and chat."***
> Female, age 80+.

Beyond these group physio sessions, interactions with other patients appear to be limited. On one of the visits, entertainment had been booked for that afternoon and all the patients we spoke to on that day were particularly looking forward to it as it appeared it was not to be a regular occurrence.

> ***"There is an entertainer planned for later this afternoon, more events like this would be good to help pass the time."***
> Female, age 80+.

What works well:

- **Interactions between staff and patients:** on both visits, we saw some positive interactions between patients and care staff.

  We observed staff respecting patient's personal space and dignity by always knocking and waiting to be invited into patient rooms. Staff were always personable and addressed patients by their names. We noticed that the names (and preferred names where needed) of each patient was clearly displayed on each room door.

  We observed staff paying particular attention to vulnerable patients. One individual we spoke to had a possible infection; we observed staff making multiple visits to his room to encourage him to drink and keep hydrated to help him recover.

Staff were mentioned for their friendliness and efforts to accommodate patients' requests. This included care and nursing staff, as well as housekeeping and other non-clinical staff.

"Staff brilliant - any help I need give it to you straight away. they care and are always popping into my room to check I'm eating and drinking."
Male, age 80+.

- **Quality of care:** physiotherapy services were particularly values, with patients noting progress in their recovery and rehabilitation.

"The nurses and physios are not forceful when they teach me the techniques I need to use, but are encouraging and boost my confidence to give things a go for myself."
Female, age 80+.

Almost all patients we spoke to said they felt the care they had helped them become more independent. Several patients expressed that the regular input they had with occupations therapy (OT) and physiotherapy had made them feel more confident in their recovery

"Excellent care which has made me more confident more independent. I made more progress towards my recovery in 3 days at IG than I did in 2 weeks at the first home they sent me which was not appropriate."
Female, age 80+.

All patients are provided with call pendants so they can easily request assistance when needed.

- **Location and environment:** several patients commented on the cleanliness and privacy when needed.

"Very happy with own private room with tv and fridge facilities which has made it more comfortable."
Female, age 80+.

All patients agreed it was easy for friends and family to visit them at the home and they are made to feel welcome.

They can come and go whenever they want, no set times. Not rushed out."
Female, age 80+.

Areas for improvement:

- **Staffing:** some patients mentioned shortages in staff, leading to delays in attending to their needs and providing therapy. There were concerns about staff appearing rushed and under pressure.

> ***"The nursing staff at care staff at Ings Grove have always been caring and done their best but there isn't enough of them to meet everyone's needs."***
> Female, age 80+.

"Staff feel rushed, they do a great job and come when they are called (sometimes takes them a while at busy periods) and they always do their best but I feel like they are always under so much pressure to move on."
Male, age 65-79.

"Expected to get more physio input than I did at the hospital but I've not had much more as they seem to be short-staffed."
Male, age 80+.

One individual highlighted concerns about delays in response to calls for assistance, leading to accidents and embarrassment.

> ***"I need support to walk and go to the toilet and need to go urgently. Staff don't always come to me in time when I call and that results in and accident which is embarrassing. The staff to their best but there seems to be a shortages."*** Female, age 65-79.

- **Independence and mobility:** we had feedback from one patient who told us the precautionary measures that had been put in place had taken away her independence and the impact this had on her.

"I am far less independent now than I was before coming here. Since coming to IG I have been forced to wear incontinence pads as when I call for assistance to use the bathroom the staff take too long and so I have an accident. I have never in my life struggled with incontinence prior to my stay here. I accidently knocked over a drink one day and since then have been told I have been 'deemed a risk' and must therefore drink all my fluids through a sippy cup. I am a proud woman who prior to my injury was wholly independent and I feel I have been reduced to an infant."
Female, age 80+.

- **Communication:** several patients expressed uncertainty about how long they would be staying at the intermediate care setting, and they wished for clearer communication regarding their expected duration of stay.

"I've no idea how long I will be here. My daughter has asked the staff a few times but we're never really given an answer."
Female, age 60-64.

"It would be good to know how long they expect to keep me here, I've asked but the response I get is vague."
Female, age 80+.

- **Outdoor access and social activities:** patients wanted more opportunities to enjoy the surrounding grounds and adjacent park, as well as more organised events and entertainment to help pass the time.

"Nice views of the surrounding grounds and park, shame I've not been outside to enjoy them."
Male, age 80+.

The lack of fresh air and outdoor time was highlighted as impacting wellbeing.

"More opportunities to go outside - the only times I have been outside in the last 8 weeks are when I have been getting into transport to be moved to a new location or to go to the hospital for a scan/treatment. No one has considered the impact it has had on me not being outdoors and having fresh air for weeks on end."
Female, age 80+.

Moorlands Grange, Huddersfield

Description of service:

Moorlands Grange is a 10-bed unit offering intermediate care. Its purpose is to support hospital discharge and reduce the risk of hospital readmissions through rehabilitation, helping individuals regain their independence before going home. Kirklees Council manages Moorlands Grange to provide short-term rehabilitation support in partnership with Locala's Intermediate Care Team which is based on site.

Moorlands Grange is supported by staff from Kirklees Council and Locala. Nurses, doctors, and therapists carry out assessments and regular reviews. They work with patients to set goals and plan the best way forward in their recovery. Patients are supported to manage their symptoms and illnesses and work towards their return home or move to another care facility. Depending on the needs of the patient, support is provided by occupational therapists, physiotherapists, specialist nurses, pharmacists, social care assessors, and other support workers. Patients are actively involved in their rehabilitation and encouraged to participate in activities that aid recovery, such as mobility practice.

Key themes from our engagement at Moorlands Grange:

Overall, patients had many positive things to say about their time at Moorlands Grange, particularly noting the kindness and support from the intermediate care staff, the quality of the food, and their rooms. However, some areas for improvement were highlighted:

- Patients acknowledged the caring and positive attitudes of the permanent intermediate care staff overall but raised concerns about staffing levels.
- The support from occupational and physiotherapy teams was highly valued, with patients noting its positive impact on their wellbeing, confidence, recovery, and independence.
- Lack of communication and planning between services, especially regarding discharge plans, medication, finances and geographical location of discharge destination.
- Patients often spent a considerable amount of time alone in their rooms, leading to potential isolation and loneliness.

Overview of our visit
We visited Moorlands Grange on three occasions during March and April 2024 and spoke to 11 patients. They had been discharged into the care of Moorlands Grange from Dewsbury, Huddersfield, and Calderdale Hospitals. One person had originally been a patient at Leeds General Infirmary, transferred to Huddersfield Royal Infirmary, and then discharged to Moorlands Grange. Demographics can be seen in Appendix 1.

On all three visits, staff were aware of our scheduled visits and helped advise us which patients were willing to speak with us and those unable to do so due to infection or isolation measures.

Environment:
The environment was warm, relaxed, and welcoming. There was a touchscreen pad to key in visitors and staff details and security measures included a locked front door requiring staff permission for entry. Corridors were clean, bright, hazard free and had no foul odours. The rooms were of a good size, well-fit with natural light from the windows, and patients appreciated the privacy of their own room with en-suite facilities. There is a designated smoking space at the front of the building.

> **"Think it is lovely here."**
> Kirklees, female, age 65-79.

> ***"It has been grand. Having my own private room and bathroom, having some privacy is nice."***
> Kirklees, female, age 65-79.

Moorlands Grove has a dining area, communal room, small conservatory space, garden and kitchenette which patients and visitors are all able to access. Although, we did not observe anyone using the conservatory or garden, likely due to cold weather, the communal areas were pleasant. The communal lounge had a television and high-back, wing-style seating, and we observed some patients using this space. There is also a separate area for meals and activities to encourage socialising and we did observe some patients sat at the tables finishing their lunch.

The care provided at Moorlands Grange:
Patients were asked to rate the care they received at Moorlands Grange and the average rating was 4.9 out of a possible 5.

What's working well:

- **Interactions between staff and patients:** all observed interactions between patients and care staff were positive.

We observed staff respecting patients' personal space by knocking and waiting to be invited into the patients room. Staff were friendly and addressed each patient by their chosen name. Patient names were displayed on each room door.

We were able to see staff offering each patient refreshments and paying particular attention to vulnerable patients, sitting with them or nearby throughout their time in the communal area.

> ***"I can't complain the staff are lovely and very helpful."***
> Kirklees, female, age 80+.

> ***"I have had very good care at Moorlands, staff are busy but get prompt responses when I press buzzer and help is available when needed."***
> Kirklees, male, age 65-79.

- **Quality of care:** the majority of patients had very few concerns during their time at Moorlands Grange. Several mentioned how helpful staff were. Almost all felt the care received had helped with independence.

> ***"Transferred from hospital to Moorland Grange it is nice area, quiet and staff are nice everything provided."***
> Kirklees resident.

"Brought to Moorlands Grange and the care received since discharge has been very good, no complaints."
Kirklees resident.

Several patients highlighted the support from the occupational therapy and physiotherapy teams.

> ***"The staff are lovely , very helpful "I have been seen by physio and they explained they are going to help with movement in hand."***
> Kirklees, female.

"Once I got physio started I could talk to the OT (occupational therapy) and they gave me support and information about a lot of stuff about what was needed to make me mobile and get better."
Male, age 50-64, Kirklees.

- **Food:** patients commented positively on the quality and choice of available food.

"Menu choice is very good."
Male, Kirklees.

"Food is good three meals a day and prepared, variety and asked what I would like they and ask you what you want for the next day."
Male, Kirklees.

- **Visiting:** two thirds of patients felt it was easy for their friends and family visit.

"I live local so easy for family to visit."
Female, age 65-79, Kirklees.

"Family member is visiting today. Social worker has been a few times."
Male, age 65-79, Kirklees.

Areas for improvement:
While many patients were satisfied with their care, some suggested improvements:

- **Better information and communication:** patients would appreciate an explanation of what to expect from Moorlands Grange when they arrive, along with more information about financial assessments and medication.

"There's a feeling of abandonment so I think prior to discharge a MDT should provide you with information pack for patient carers."
Male, Kirklees.

"I came here and they brought me upstairs to my room . But no one discussed financial assessments. I think it was the social worker who got me in here and she keeps popping in to see me. She is trying to sort out plans for me to move back home."
Male, age 65-79, Kirklees.

"I was given the name of where I would be going, it wasn't a choice or options given. There was no mention there would be dementia residents also there. I was not given explanation of what I would be doing at rehab."
Kirklees resident.

"Only issue I had was not getting all my medication here which had to get a doctor involved and pharmacist. Better communication and information around this and potential side effects of withdrawal and changes in medication."
Male, age 50-64, Kirklees.

"No discussion on financial assessment. I know I am due to go home soon but there has been no discussion yet of how I am getting home and how the equipment I need will get there either, I wonder if it will come with me."
Male, Kirklees.

- **More activities in communal spaces to prevent isolation:** a couple of patients commented on the lack interaction with others and from our observations it did appear they spent most of the time in their room, broken up only with visits from external visitors and care staff. We were able to see some patients had book, newspapers, magazines, and other items bought in by family and friends to help pass the time. There was no mention of an activities program outside of physio/occupational therapy to encourage social engagement.

  One patient told us of a volunteer companion services and they would have liked to have given the option to access this.

"I wasn't told of a companion service, that may have helped with these feelings, this should be offered to everyone, especially if like me you are out of area, this could have helped when I couldn't get out of bed - it felt worse than being in prison."
Male, Kirklees.

- **Capacity of service:** some patients commented on how busy care staff were. One person said that due to care staff supporting other patients, they were hesitant to ask for help despite having mobility issues and struggling to get washed and dressed, they didn't want to put further pressure on staff, so took it upon themselves to use a chair to assist them.

"Staff are kept busy with some demanding patients but still have time to come and help me when possible. But I mainly do things for myself like go to the bathroom and dress myself, having a wash can be difficult which I sometimes struggle with and if I ask nurse helps me with this when they can, I have difficulty due to issues with my feet."
Male, age 65-79, Kirklees.

- **Visiting:** a couple of patients noted that the location of Moorlands Grange made it difficult for their friends and family to visit.

"The distance and location from where I lived to where I would be staying meant it was difficult for friends to visit. They would struggle to find me and I think not having visitors impacts on recovery."
Male, Kirklees.

Oak Unit / Brackenbed View, Halifax

Description of service:

Oak Unit is an Intermediate Care Unit on the lower ground floor of a care facility in Halifax. We were advised there were 24 rooms in the intermediate care area but some were for long-term residents and not all rooms were occupied during our visits.

The unit has had various names, including Oak Unit and Brackenbed View. Online the facility is also listed as Eden Court Care Home. It had changed ownership prior to our visit and we briefly met with the new owner on the first visit. A manager had left between our 2 planned visits.

There is a care facility on the upper floors which is known as Pellon Lane Care Home. The signs outside say Brackenbed View and Pellon Lane Care Home.

Patients can stay in the unit for up to six weeks in a private room with an en-suite bathroom.

As well as care staff, there are also NHS staff working on the unity including physiotherapists and nurses.

Key themes from our engagement at Oak Unit:

- 75% said the discharge plan into Oak Unit **has** met their needs and most people were happy with the care they received. .
- 50% of people at Oak Unit told us they were **not** involved in financial discussions around their case: 38% said they had been involved and 12% did not know.
- 87% of people told us it was **easy** for family and friends to visit them on Oak Unit.
- On both our visits 50% of the people we spoke to were **unhappy** with the food, commenting on temperature of it and choices available.
- 50% of people told us they felt there were **not** enough carers.

Overview of visits:
We visited Oak Unit twice during our engagement and spoke to 8 patients who were receiving care here. Demographics can be seen in Appendix 1.

We were told the care staff and NHS staff both work for the unit and we were introduced to someone from both.

Care staff advised us on who we could not talk to (one long-term patient and one for health reasons) and then left us to introduce ourselves.

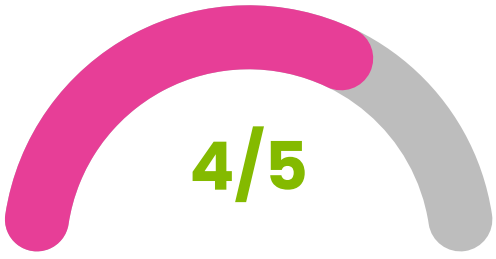
Environment:
The rooms nearest to the entrance area are noisy and this was noted by a patient and by Healthwatch volunteers.

The rooms were clutter-free, apart from the walking aids, and there was a whiteboard showing patient details. Most of the patients had their doors closed, but we left them open whilst talking to them.

The patients appear to stay in their rooms, with no one accessing the communal area during our 2 visits. The 8 people we spoke to also told us they stayed in their rooms apart from when physiotherapists worked on improving their mobility by walking with them in the corridor. There didn't appear to be any activities available apart from watching TV.

One patient told us a urine bottle was placed on the table they ate from, which clearly presents hygiene issues.

The care provided at Oak Unit:
We asked patients to rate the care they received at Oak Unit and the average was 4 out of a possible 5.



What works well:

- **Quality of care:** most patients seemed happy with the care they were receiving; some were reluctant to think about going home, where others wanted to work hard on their rehabilitation so they they could return home as soon as possible.

> ***"I like it here at Oak, if someone could come now and tell me I was a stopping I would be happy."***
> Female, age 80+.

"I can go for a walk, manage to get to the next room as it's a straight flat surface. Going home is a step too far, it's a non starter to go home. I feel this eases the pressure."
Female, age 65-79.

"It's up to me to help me get better, the more I do the sooner I can get home which is what I want."
Male, age 65-70.

"Broke leg, was in hospital 7 weeks, don't know how long here but had a lot of help here at Oak Unit. Friendly & kind."
Calderdale, female, age 80+.

There was praise for the physiotherapy staff based at the unit.

"I am getting better, the change in the last 2 weeks has been massive, it's the physio that has benefited me the most."
Calderdale, male, age 50+.

On both visits we saw some interaction between patients and care staff and all were positive.

What could be improved:
Overall, patients were content with their stay, but a few challenges and areas for improvement were highlighted:

- **Food:** there were a few negative comments about the quality and quantity of food provided.

"How can it be made better? Trolley of food goes all round the home and its cold by the end, which is us. Food: tiny piece of stew, some potato, green beans, few pieces of meat".
Female , age 80+.

"Wobbly couple of days with food, change over of provider, awful. Needs consistency with food."
Female, age 80+.

- **Staffing:** some patients commented that there were not enough carers and that is was unclear who was responsible for different aspects of their care.

"I had people waking me up to do with tablets, so had little sleep last night. Staff have different approaches and they respond to me differently. I asked one about breakfast and she said she doesn't do that, her job was different but I didn't know that."
Female, age 80+.

"More carers."
Female, age 80+.

"You can't expect the same standards as in hospital. I had to go for two weeks without a shower due to staff shortages."
Demographics not provided

"Different people from each dept that I cannot keep up with who is who."
Female, age 80+.

- **Information about financial matters:** 62% of patients were **not** involved in discussion about financial plans, or could not recall if they were. As a result of this, all assumed the stay at Oak Unit was non-chargeable and a continuation of hospital care.

  One patient was told they may need to pay for prescriptions, which they were unaware of until some weeks into their stay at Oak Unit. It meant they had to apply to the Department for Work and Pensions for financial assistance due to being working-age and unable to work. They did this while on the unit.

- **Environment and equipment:** one person felt the environment and equipment provided limited their recovery.

"Carpet corridor, I can walk easier but in the room its hard flooring. I am getting training but it's not the right environment. Train on hard floor. Feel I can manage here but it's hard in the corridor. Sticks and frames, different based to what I have at home. Difference in strength needed to move with it."
Female, age 80+.

- **Information about what happens next:** one person seemed to be quite anxious about what would happen with their personal care once they leave the Oak Unit.

"What worries me most is toilets, people who will come into my house will they be able to help with that or washing or getting dressed?"
Female, age 80+.

Oak Unit case study

Patient A has been in the care of the NHS and intermediate care for 6 months.

"I was told I was at risk of a cardiac arrest and was taken by ambulance to HRI where I stayed for 6 weeks. I was discharged onto the Oak Unit and I only came here because I knew I would get the physio I needed. But I then had to return to hospital when my blood pressure when so high they had nothing to prescribe, so they called an ambulance and in was taken to CRH into A&E....

There are issues at Oak Unit, some of the things here are shocking. They've put a urine bottle on the table where my food and drink also comes, it's in case I cannot get assistance to go to the toilet so the bottle gets emptied into the toilet they put back on the table. It's not cleaned. I bought my own bleach in.

I was on lots of medication and they told me I might have to pay for them, even they weren't sure. I knew nothing about it and assumed it was all provided so now I've had to apply to the DWP to see if I am eligible.

I am getting better, the change in the last 2 weeks has been massive, it's the physio that has benefited me the most. I have frames and can get about slowly, but I'm mostly in this room.

I am still in a gown as I feel putting my clothes on will make it more like home and I don't want it to feel like home, I want an incentive to get out. I need physio to continue, I can do bits myself but that's my way back to how I was. That needed to have started sooner and to be more intensive. I don't know when I will leave here but I hope the physio doesn't stop when I do leave."

Transitional beds in Calderdale
There are two facilities providing transitional beds in Calderdale: Valley View and Cedar Grange.

Cedar Grange
This setting had no patients staying during our engagement period and had just one patient stay since they started offering the service in November 2023 and the person remained there until February 2024. Staff here felt the service could be used more to support people leaving hospital.

Valley View
Healthwatch Calderdale visited this setting in April 2024 and spoke to three patients staying under the transition bed contract.

Staff felt the patients were in a holding position while they were assessed for the next move, unlikely to be home. Patients receive care but not nursing or physiotherapy care.

Patients found the staff to be helpful and friendly.

Feedback from 3 people about whether they were involved in plans for discharge into a transition bed was negative – 1 said no; 1 didn't know and 1 preferred not to answer.

Just 1 of the 3 felt ready to leave hospital, and none were sure prior to discharge if the discharge plan had met their needs and 2 were unsure what to expect.

"Not sure how long I was going to be here. It got me out of hospital and I'm more comfortable staying here until longer term plan can be made for my care. It would be good to know how long I will be here. I am waiting on finding care home but I've not been told how long that will be. I know my daughter keeps asking but we never get a solid answer."
Calderdale, female, age 80+.

"Meals are good I've no problems I like it here. I don't know if they spoke to my family about (finance)."
Calderdale, female, age 80+.

Section 3 - Support at home for reablement services

Description of service

Reablement, also known as 'Home First,' is a short-term, intensive service that helps people maximise and maintain their independence at home after being discharged from the hospital. The service aids individuals in regaining the skills and confidence needed to live independently. This may include practicing daily activities such as cooking and bathing, finding ways to enhance safety and confidence, supporting therapy plans, and considering other options to support independence at home, such as assistive technology, equipment, or home alterations.

Kirklees reablement

Key themes:

- 93% of people say the reablement care they received helped them to be independent. 69% of family members felt the same.
- 66% of people viewed reablement positively and some praised the quality of care, skills, and kindness of staff. However, there were numerous suggestions for how the service could be improved to offer a more personalised level of care.

Overview of engagement:

We spoke to 17 people receiving care from Kirklees reablement service and 27 family members via telephone: 85% women and 14% men. Demographics can be seen in Appendix 1.

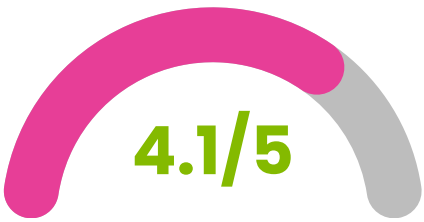
All contacts we spoke to were provided to us by the reablement teams in Kirklees and Calderdale, with the person's consent.

The care provided by Kirklees reablement service

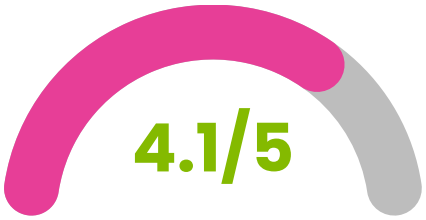
Rating:

We asked people to rate the care they received from the reablement service and the average rating was 4.5 out of a possible 5.

The average rating from family was 4.1 out of a possible 5.



People were also asked to rate health services involved in supporting the person at home and the average rating for this was 4.1 out of a possible 5.



The average rating from family was 3.5.

The discharge with reablement was viewed positively by two thirds of people receiving the care but more negatively by family members just over half saying it did not meet their relative's needs or they did not know if it met their needs.

What has worked well:

- **Quality of care:** there was praise for reablement staff, with gratitude for what they do in supporting and encouraging independence and confidence in health and wellbeing.

"The carers in [my] home pushed me to get back on my feet, more confident."
Kirklees, female, age 80+.

"That people were coming and checking that I was safe was very valuable to me as I live in a very isolated area. It was very reassuring to me and I have missed it since it stopped."
Kirklees, female, age 80+.

"My overall health improved almost instantly when I got home. I think I was in hospital 2-3 days longer than necessary so the fact that I was able to come home and be supported by the home first team made a big difference to my recovery from the onset."
Kirklees, male, age 65-79.

Relatives also gave positive feedback about the care received.

"Carers nice and kind. Good to know patient was being checked on. Good carer communication to family member (carer)."
Demographics not provided

"Carers are well trained and help her but don't mother her. They have helped her to build confidence and are empowering her to be independent by not mothering her and doing tasks for her but proving her with reassurance and support."
Demographics not provided

Someone who was unsure whether reablement would work for her relative found that it worked well in the end.

"I personally didn't feel she was well enough to leave the hospital but the information they gave me about what care she would receive in the home did help reassure me and to be honest it has all worked out very well and she had recovered well at home."
Kirklees, female, age 65-79.

- **Developing or regaining independence:** 93% of people say the reablement care they received helped them be independent. 69% of family members felt the same.

"The support did its job, it got me through my recovery and meant I was able to stay at home even though I live alone."
Kirklees, female, age 65-79.

- **Waiting time for equipment or adaptations:** 75% didn't have to wait for any equipment or adaptations, with 73% needing items such as a toilet raiser, frame, or adjustable bed.

What could be improved:
In the comments given by people and their family members the key themes were:

- **A need for specific visit times:** people want to visit to be at the right time for their lifestyle.

"Sending the carers to me at 5pm was far too early for [getting ready] for bed."
Calderdale, female, age 80+.

- **Longer and more flexible visit times:** one person said they would have appreciated a little more support until the person was further on their recovery.

"Longer call times and a bit more flexibility to allow for some extra tasks around the home that would help patients until they are well enough to do it for themselves."
Kirklees, female, age 65-79.

- **Improved communication:** one person reported difficulties when her care was transferred from reablement to a care company.

"When my care was handed over from the reablement team to You Care there was a lot of confusion and I had both carers showing up for a few days so there is room for some communication improvements there..."
Kirklees, female, age 80+.

- **Information about financial matters**: 64% of people told us they were **not** involved in discussions about financing adaptations or the cost of any care, with 47% of family members telling us the same.

"I asked the question about who pays for what, it wasn't forthcoming."
Kirklees, female, age 65-79.

"My care has now been transferred to a You Care company, I have been given a rough estimate as to how much this care costs but no assessment to see if I am to pay for the full bill or entitled to support."
Kirklees, female, age 80+.

- **Reablement not provided in a timely way:** reablement wasn't always provided within a timescale that met the needs of the person who had been discharged and their family. This can put a lot of pressure on families at an already difficult time.

  60% of people were visited by someone from reablement within 2 days of arriving home.

"There was no reablement support for two full days, three nights. The discharge team said my Mum could come home if I agreed to care for [her] in the interim period. I didn't feel I had a choice but to say yes. My Mum was not ready, the bed was the wrong height, I had a nightmare getting her into bed at night, she was also sent home with no lifeline alarm. The family had to provide 24/7 care for several days, it was hugely stressful. No physio for several days. Reablement team when they started were lovely but rushed at every call."
Kirklees, family member, female, aged 50-64.

Patients, carers, and family members also asked for contact information for all organisations involved in the care to be shared with family on discharge, for them to have sight of any risk assessments and to be able to input into them. As well as services to consider signposting to support the services outside of the NHS and social care, such as voluntary or community sector services that can provide the patient or family members with ongoing support once reablement has ended.

Calderdale reablement
Key themes:

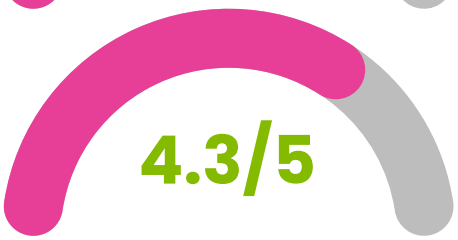
- 64% told us the discharge plan with reablement met their needs.
- 82% told us that reablement helped them to be independent.

Overview of engagement:
We spoke to 17 patients or family members via telephone: 9 women and 7 men. Demographics can be seen in Appendix 1.

The care provided by Calderdale reablement service Rating:

- 4.5 average rating for social care.

- 4.3 average rating for health care after discharge.



What has worked well:

- **Quality of care:** most people appreciated the care they'd received and felt it worked well for them.

> ***"I haven't had to think of doing much for myself like preparing meals, and I have enjoyed the visits I have had. It feels reassuring to share my worries or know someone will check on me and if I do fall it won't be long until someone notices."***
> Calderdale, Female, age 65-79.

"My late wife had previously used the reablement service so I knew of it and what to expect and I have been very happy with the way everything was done. It has all gone smoothly."
Calderdale, male, age 80+.

"The carers have been very good, if I am not there when they have the call they leave very detailed messages in a book for me to catch up on later and I can see what time they came and left, what they did for her, if she's had a wash etc and how much she took part herself for example if she helped with making her own dinner etc which has been very useful for me."
Demographics not provided

- **Developing or regaining independence:** reablement has helped 82% of people to be independent.

- **Timeliness of service:** just over half of people (58%) saw someone from reablement within 24 hours of getting home, with 18% receiving care up to 2 days after discharge.

"Initially had care within the first 72 hours from the emergency care team before reablement had the capacity to take over."
Calderdale, female, age 65-79.

What could be improved:

- **Providing longer or more flexible reablement packages of care:** some people told us they didn't feel the six weeks reablement was long enough, or that the initial care package was too limited.

"Six weeks wasn't quite enough time for me."
Calderdale, female, age 50-64.

"The care package I had initially for was for 3 visits a day to help be prepare my breakfast lunch and dinner but I soon found that I was able to do this for myself and more so struggled with getting dressed and washing myself and walking upstairs to get to bed on an evening. They then said because I didn't need support with getting meals ready they would cut down the package and it was changed to just one call a day at tea time to make sure I had eaten. This didn't make sense to me because if I hadn't been able to manage to get myself a meal why only come at tea time to check. They knew I was able to feed myself and I told them it was the getting upstairs, washed and ready for bed I struggled with so sending the carers to me at 5pm was far too early for this. I asked if they could come later but I was told no."
Calderdale, female, age 80+.

- **Discussions about financial assessments or impact:** 62% told us they were **not** involved in discussions about finances.

"Everything was organised for me, I didn't have the worry of having to get people in to sort things. I do not know what it cost or who paid for it so hope I won't get a bill or I get some warning of a bill."
Calderdale, male, age 65-79.

- **Equipment and adaptations:** just over half of the people returned home with equipment provided or adaptations having already been done. However, some had to wait for equipment or adaptations; 18% said up to 1 week, with the same number saying 1 week to 1 month.

"Home adaptations to be carried out prior to discharge."
Calderdale, male, age 65-79.

"I was desperate for a shower but had to wait for over a week before grab rails were installed. Given it was a planned procedure I went in for I was hoping that could have been sorted before I went in or the very least before I was discharged."
Calderdale, male, age 65-79.

- **Reablement not provided in a timely way:** some people had to make alternative arrangements before they were then provided with reablement at home.

"I would have preferred to go straight from hospital to my own home with the care in place than having to move to my sons and then be moved again home."
Calderdale, male, age 80+.

"Initially had care within the first 72 hours from the emergency care team before reablement had the capacity to take over."
Calderdale, female, age 65-79.

Section 4 - Carer's experience

37 carers told us about their experience; three-quarters of their relatives had been discharged home with reablement support.

Feedback from carers has been incorporated into the themes throughout this report, however, some carer-specific themes are shown below:

- Only a third of carers had been given information about how they could access advice and support for carers.
- Just half of carers said they were given information about who they could contact following discharge if they needed further advice and support.
- Some carers commented on the pressure they felt due to having to provide care to their relative following discharge from hospital.

"Practically had to give up [my] job. Felt lonely scared and frustrated with this huge responsibility on [my] own."
(Kirklees resident).

"He is on his own at home. Lot of pressure on family to support and care for an elderly person living on their own who was still unwell with a numerous medical conditions. As a family member [we were] quite shocked at discharge after only 2 nights admission."
(Kirklees resident, male, 80+).

Section 5 - Health inequalities

Throughout this engagement, the Healthwatch engagement team noticed that they were speaking to very few ethnically diverse people. Most people in the intermediate care bed settings were White British, as were the people receiving reablement support who spoke to us on the phone.

We requested ethnicity data on hospital admissions and referrals to intermediate care and reablement. The data shows a disparity between people who access these services from White British and other ethnicities.

Healthwatch would like to understand this in more detail. So, there will be an additional piece of engagement to look at whether there are reasons why some ethnically diverse people decline intermediate care and reablement, and whether there are any particular barriers around access.

Section 6 - Age UK's Home from Hospital Service in Kirklees and Calderdale

Working in partnership with Community Transport in Kirklees and Calderdale, this service provides transport home and support after a stay in hospital.

They take weight-bearing clients from the age of 50 + home from hospital and spend time settling people back in at home making sure they have food, heating, and electricity but most importantly they make sure people are safe and secure in their home before they leave them. They can connect people to other sources of support such as befriending, cleaning, wellbeing, and dementia support services.
Age UK offers a different service in Kirklees than in Calderdale. To get information about what they provide, you can find more information on their website - Age UK Calderdale & Kirklees | Home from Hospital

In Calderdale, the service can provide a 6-week personalised package to meet the individual's (and their carer's) needs and focuses on re-engagement and maintaining independence. The service can include things like regular phone calls, home visits, prescription collections, and support to visit local community groups.

Healthwatch met with Age UK's Home from Hospital Service to understand more about how the service works and whether there are occasions when things don't work as well as they might. Some of the things highlighted were:

- Discharge home with support from Age UK's service works well in the majority of cases and people who receive this service are appreciative of the care provided.

- Staff mentioned that sometimes there are problems with people returning home to no gas/electricity, no food, and unclear medication instructions. When discharge happens late in the day it can sometimes be more difficult for Age UK to get such things sorted out for the person returning home.
- Occasionally, discharges fail as it is simply not safe to leave the person at home. This can mean contacting the ward or discharge lounge and the person has to be readmitted, or the person has to be taken to A&E.

One person told us that they hadn't been provided with enough information about Age UK's Home from Hospital service:

"Promote Age Concern's Home from Hospital service more widely. The Home from Hospital reablement service wasn't really explained, misleading"
Demographics not provided

Conclusion

This report highlights areas for improvement through the discharge planning process in hospitals, as well as in intermediate care settings and reablement at home services.

Hospital Discharge Planning
Patients have reported feeling uninvolved in their discharge planning, with some finding themselves discharged to unsuitable places and not feeling prepared or well enough to leave the hospital. Sometimes the discharge process itself is often perceived as rushed and not well planned. Additionally, there is a notable lack of information provided about the services patients are discharged to, and a lack of written information about who to contact for further advice or support post-discharge.

Despite these issues, hospitals have been acknowledged for their efforts in providing care and treatment, and there is recognition of the dedication of healthcare staff amidst challenging circumstances.

Intermediate Care Settings
Patients have expressed a high level of satisfaction with the care and support in intermediate care settings, particularly praising the friendly and respectful interactions with staff and the quality of physiotherapy. However, concerns have been raised regarding the adequacy of staffing levels, which patients feel are insufficient and negatively impact the quality of care.

Furthermore, while patients appreciate the privacy of having their own rooms with en-suite facilities, the lack of social interaction, activities, and outdoor access can lead to feelings of loneliness, isolation, and disconnection, adversely affecting both physical and mental health and potentially delaying recovery.

Reablement at Home
Reablement services at home are generally well-received, with the majority of people reporting that the care they received has significantly contributed to their independence. The skill and kindness of the staff are particularly praised. However, there are suggestions for improvement, such as extending the duration of reablement, offering more flexible care packages, and ensuring timely provision of services without relying on family support to fill gaps.

Equity
Healthwatch has concerns about potential inequality in access to reablement and intermediate care beds for ethnically diverse people. Healthwatch is undertaking additional engagement to understand and address this better.

In conclusion, addressing the challenges highlighted in this report will require a concerted effort to improve communication, involve patients in their care plans, and ensure adequate staffing and support across all settings.

Our list of recommendations can be found on page 2 of the report.

Appendix 1

Demographics

Ings Grove House

We spoke to 16 patients; 9 women and 7 men during 4 visits between 22 Feb and 9 April 2024. We received 2 additional responses via social media from a relative or friends of a person who received care at Ings Grove House.

The ages of the individuals we spoke to were:
80+: 9
65-79: 4
50-64: 2
Prefer not to say: 3

15 patients were retired and 1 was unable to work due to his health needs/disability (2 did not provide their employment status).
13 patients were White British, 1 White Irish, 1 White any other background, and 3 preferred not to say.

12 had long-term conditions including a respiratory condition, musculoskeletal conditions, Parkinson's, and cancer. 6 patients had a physical disability, 2 had sensory impairments.

All were Kirklees residents.

8 patients had been discharged from Huddersfield Royal Infirmary, 5 from Dewsbury District Hospital, 2 from Calderdale Royal Hospital, 2 from Pinderfields Hospital, and 1 from Pontefract Hospital.

Moorlands Grange

We visited Moorlands Grange on 3 occasions during March and April 2024 and spoke to 11 patients: 5 men and 4 women (2 didn't provide this information). All live in Kirklees.

The ages of the individuals we spoke to were:
80+: 2
65-79: 4
50-64: 2
25-49: 1
18-24: 1
1 skipped the question

5 people had physical/mobility needs, 1 sensory, 1 mental health condition, 1 long-term condition, and 1 hearing impairment. 1 person had no disability.

1 person had a cardio-vascular condition, 2 Deafness/hearing impairment, 1 Mental Health, 3 Hypertension, 2 Diabetes, 1 IBM, 1 Thyroid, 1 Colitis, and 1 Glaucoma.

1 person said they were a carer.

8 people were British, 1 Arab, 1 European, and 1 person preferred not to say.

Oak Unit/Brackenbed
We spoke to 8 patients during 2 visits; 6 women; and 2 men.

The ages of the individuals we spoke to were:
80+: 5
65-79: 2
50-64: 1

5 had long-term conditions including heart failure, diabetes, stage 3 kidney disease, hypertension, and Polymyalgia rheumatica.

The 2 men were in the 50-64 and 65-70 age bands and both had long-term multiple complex medical needs.
The women were 65 and older and frailty was the main barrier to them returning home.
All were British. All retired but 1 said they were semi-retired.
All had physical mobility needs.

All patients were Calderdale residents. 2 told us they lived in a rural/isolated area and were without a nearby support network.

Kirklees reablement
We spoke to 17 people receiving care from the reablement service and 27 family members via telephone: 85% women; and 14% men.
61% of them said they had a physical or mobility issue, and 15% did not have a disability.

The ages of the individuals we spoke to were:
80+: 50%
65-79: 28%
50-64: 7%
25-49: 7%

71% were retired with 28% of working age but unable to work due to health or disability.
All identified as white British.

Calderdale reablement
We spoke to 17 patients or family members via telephone: 9 women and 7 men. 69% of them said they had a physical or mobility issue and 30% did not have a disability.

The ages of the individuals we spoke to were:
80+: 43%
65-79: 50%
50-64: 1%

healthwatch

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