healthwatch Havering

DISCHARGE FROM HOSPITAL

Current arrangements in Havering

A submission to the
Special Inquiry by Healthwatch England
into arrangements for discharge from hospital

Healthwatch Havering is the operating name of
Havering Healthwatch Limited
A company limited by guarantee
Registered in England and Wales
No. 08416383

What is Healthwatch Havering?

Healthwatch Havering is your new consumer local champion for both health and Adult care. Our aim is to give local citizens and communities a stronger voice to influence and challenge how health and Adult care services are provided for all individuals locally.

We are an independent organisation, established by the Health and Adult Care Act 2012, and are able to employ our own staff and involve lay people/volunteers so that we can become the influential and effective voice of the public.

Healthwatch Havering is a Company Limited by Guarantee, managed by three part-time directors, including the Chairman and the Company Secretary. There is also a full-time Manager, who co-ordinates all Healthwatch Havering activity.

Why is this important to you and your family and friends?

Following the public inquiry into the failings at Mid-Staffordshire Hospital, the Francis report reinforces the importance of the voices of patients and their relatives within the health and Adult care system.

Healthwatch England is the national organisation which enables the collective views of the people who use NHS and Adult services to influence national policy, advice and guidance.

Healthwatch Havering is your local organisation, enabling you on behalf of yourself, your family and your friends to ensure views and concerns about the local health and Adult services are understood.

Your contribution will be vital in helping to build a picture of where services are doing well and where they need to be improved. This will help and support the Clinical Commissioning Groups and the Local Authority to make sure their services really are designed to meet citizens' needs.

'You make a living by what you get,
but you make a life by what you give.'
Winston Churchill

1. Introduction

In March 2014, Healthwatch England announced that it was launching a Special Inquiry -

> **"… to find out what happens when people are discharged from a hospital, care home or secure mental health setting. We will focus on understanding the experiences of homeless people, those with mental health conditions and older people. Early on, local Healthwatch had told us this was a priority issue and we agree it's time to take action at a national level.**
>
> **"For too long people around the country have not had the right support in place for when they leave a hospital, secure mental health setting or care home. Your work has shown that this results in people being frequently left isolated and in crisis in our communities, which has a big impact on people's lives. Like you, we think that this could have been prevented if people were put at the heart of the decisions that are made about being discharged and the on-going support they would need afterwards.**
>
> **"Healthwatch England is using our statutory powers to undertake a special inquiry into people's experiences of being discharged from a hospital, care home or secure mental health setting. This problem had been a legacy concern of the LINKs network and it has also been escalated to us early on by the local Healthwatch network as an area of significant concern. When our inquiry reports in September 2014 we will use the evidence collected through the inquiry and our statutory powers, to advise the Secretary of State for Health and any relevant statutory bodies (like NHS England), about changes that should be made to policy and guidance or practice."**

Healthwatch Havering shares the concerns that have been expressed across the country. Although local experience in Havering does not suggest that the problems of inappropriate discharge may be as serious as in other parts of London or elsewhere, even a single instance of inappropriate discharge is one too many – the distress and anxiety caused to vulnerable (and more than likely, confused) elderly or other people by being left in what could well be unfamiliar or unprepared surroundings can be incalculable.

In 2011, the former Havering Local Involvement Network (LINk) had reported to Havering Council's Health Overview & Scrutiny Committee

(OSC) on hospital discharge arrangements in the borough, making some 32 recommendations for improvement.

The LINk report was followed up by the OSC during 2013 and 2014 by a Topic Group of OSC Members to which the LINk (in its final days) and Healthwatch Havering, as the LINk's successor, contributed. Given that this work had been undertaken comparatively recently, Healthwatch Havering decided to use it as the basis of their submission to Healthwatch England's Special Inquiry rather than use scarce resources on carrying out a further investigation that was unlikely to result in anything new.

The new work undertaken by Healthwatch Havering, which looks at discharge in the wider context of patient care, is set out in Section 4.

2. Extracts from the Report by Havering LINk

The former Havering LINk published its report in 2011. The following passages are extracted from the full report (which is available on request in hard copy from Healthwatch Havering, and on its website (http://www.healthwatchhavering.co.uk/sites/default/files/havering_local_involvement_network_link_-_patient_discharge_report_0.pdf).

As a result of a survey carried out by Havering LINk and issues raised by the public and LINk members concern has grown that there appear to be gaps in the process of hospital discharge in the borough. The LINk is of the strong opinion that the process of discharge from a hospital can for some people be a trying time. Patients may need extra support when leaving a hospital which can involve making changes in their homes for improved accessibility and greater ease of physical movement as well as the practical support required due to the change in the person's circumstances.

For these reasons the LINk set up a Patient Discharge Sub Group [in 2010] and over a period of 18 months, the LINk met with many different service providers. These are

- **London Borough of Havering Adult Adult Care, Hospital Discharge Team**
- **Patient Discharge Team, Barking, Havering and Redbridge University Hospitals NHS Trust (BHRUT)**
- **Saint Francis Hospice**
- **Directorate of Workforce and Transformation, NHS Outer North East London**
- **Havering Direct, London Borough of Havering**
- **Rehabilitation Service, London Borough of Havering,**
- **Chief Pharmacist, BHRUT**
- **Logistics Procurement (Transport) BHRUT**
- **District Nursing Service, NHS Outer North East London**
- **Feedback from the public, LINk members and care homes**

The LINk made the following recommendations:

To BHRUT

- **The current process of completing the two main pieces of discharge paperwork simultaneously ("section 2" and "section 5") should be discontinued. Section 5 should only be completed when the date the patient is to be discharged has been agreed**
- **An advocacy centre should be introduced at Queen's Hospital**

- More use should be made of the voluntary sector to assist where appropriate with patient discharge
- BHRUT and NHS ONEL should work together to ensure the greater availability of rehab beds and hence reduce delays to discharge
- The inclusion of "awaiting rehabilitation beds" as a reason for delayed discharge should be scrapped; those in rehabilitation beds should be separate from the main list
- The Health Needs Assessment form should be shortened and in the case of a patient needing a third party to act for them the ward should have the name of an appropriate adult/advocate
- Paperwork to discharge patients to be started earlier, in order that care plans are finalised in advance and not on the day of release
- Elderly or vulnerable patients should not be discharged after 6pm other than in exceptional circumstances
- Patients and their families/advocates must be informed in good time when they are to be discharged
- "To Take Away" (TTA) prescribed drug forms to be completed on the ward, preferably a minimum of 24 hours before discharge
- The installation of the new pharmacy software should be completed as a matter of priority
- The medication order should be timed and dated in order to streamline the discharge process
- The "Green Bag" system for storing prescribed medicines should be publicised more and the Trust should work with charitable organisations on this subject. Ambulance staff should be encouraged to ask a patient if they have the bag on their person
- Relevant supplies of drugs should always be available and should be stored on the ward as seen in the Paediatric and Gynaecology wards
- More nurses and technicians should be trained to prescribe to enable them to complete the "To Take Away" TTA forms
- Any medication given prior to discharge should be noted on the discharge form with the time and date clearly visible particularly for prescribed medication such as Clexane or Insulin
- Correct medication to be dispensed with the patient on discharge
- All discharge letters should be clearly written and given to the patient on discharge. Any faxed copies must also be fully legible
- There should be more liaison between hospital transport and discharge

staff to ensure that District Nurses are kept up to date about the date of a patient's discharge

To North East London NHS Foundation Trust/North East London Community Services (NELFT/ NELCS)

- Occupational Therapists should carry out home visits in order to speed up the process whereby a patient's needs can be quickly identified
- The District Nurse Team should always be invited to multi- disciplinary discharge meetings
- An independent discharge co-ordinator be put in place in order to improve communication between the various parties involved in patient discharge
- Any medication given prior to discharge should be noted on the discharge form with the time and date clearly visible particularly for prescribed medications such as Clexane or Insulin
- A sticker should be placed on the Patient Held Records such as "do not remove from the patient's home"

To the London Borough of Havering

- All care homes commissioned by the Council should not expect care home staff to attend training sessions in their own time and all training should be mandatory
- Commissioners should ensure more effective training of care home staff in order that inappropriate admissions to Accident and Emergency are reduced
- The utilisation of day centres, where community rooms are not used should be explored. This could enable Occupational Therapy to be carried out and support to be offered
- In order to improve rehabilitation and hence smooth the discharge process, more use should be made of interim beds as a step down from hospital admission

To NHS Outer North East London

- More use should be made of the voluntary sector to assist where appropriate with patient discharge
- BHRUT and NHS ONEL should work together to ensure the greater availability of rehab beds and hence reduce delays to discharge
- A common language should be used to describe blister packs/dossets

To NHS ONEL and the London Ambulance Service

The "Green Bag" system for storing prescribed medicines should be publicised more

Patients Views given to the LINk

The following issues and points were raised by members of the public during the course of the LINk's review:

- **There have been reports that a discharge care plan is not in place, particularly when a patient is transferred from BHRUT to surrounding hospitals outside the borough**
- **Reports and discharge letters from doctors on the wards being illegible and GPs not being able to read them**
- **Lack of equipment which is essential to the patient not being given. This includes wheelchairs and the necessary equipment for those with sensory deprivation**
- **Home visits not being made which can cause the wrong equipment to be given to the patient. The LINk has heard reports for example of a wheelchair not fitting in a person's front door**
- **The wait for medication which has been highlighted in this report**
- **The lack of communication or delay in informing GPs of patients' needs**
- **There have been reports that a nurse does not accompany the consultant/doctor when they are doing their hospital rounds**

Care Homes

Havering LINk contacted all the care homes in the borough and the following issues were raised:

- **Discharges late at night are disruptive and not beneficial to frail elderly people**
- **The wrong medication sent home with service users which causes difficulty in maintaining good health and continuity**
- **The transfer letter sent with service users often gets mislaid and hospital staff phone repeatedly for the same information**
- **When residents are discharged from Accident and Emergency they often come back to their care home with no information. For example details of any treatment given, any medication and diagnosis made. This should also include any follow up treatment to be given**

- Trying to book an appointment with a named GP can be difficult
- The acquiring of blood test forms can be difficult
- The discharge of patients after 6pm is inappropriate and after 8pm the night staff do not have the resources to receive the service user appropriately
- Lack of information from hospitals makes it difficult to maintain continuity
- The lack of a discharge letter or if received it can sometimes be illegible

3. The current position as reported to the Overview & Scrutiny Committee

Progress with implementing the LINk's recommendations was reviewed by the Council's Health OSC during 2013 and early 2014 with participation from Healthwatch Havering as well as BHRUT, NELFT/NELCS, the CCG and Havering Adult Care. The progress reported is summarised as follows.

Background

The participants in the review were reminded that a delayed transfer of care (DTOC) occurred when a patient was ready for transfer from acute care, but was still occupying a bed designated for such care. A patient was ready for transfer when

- **A clinical decision had been made that the patient was ready for transfer AND**
- **A multi-disciplinary team (health and Adult care) had decided that the patient was ready for transfer AND**
- **The patient was safe to discharge/transfer.**

Where a patient was medically fit for discharge and the delay was attributed to Adult Social Care, the responsible Council would incur a charge of £120 for each day that the person remained in hospital.

Acute Trusts monitored:

- **Responsibility for the delay (Hospital, Adult Social Care, CCG, Share, or Family)**
- **If it was a Adult care responsibility, the Trust would identify:**
  - **The Council responsible for each patient delayed**
  - **The number of patients whose discharge was delayed**
  - **The number of delayed days**
  - **The reason for delay**

Health and Adult Social Care were responsible for:

- **Working together to plan safe and timely discharge for patients from the time a patient was admitted**
- **Jointly agreeing a predicted date of discharge**
- **Participating in Multi-Disciplinary Patient Meetings to agree Discharge Plans in conjunction with patients and family/carers.**
- **Health led on ensuring that at the earliest possible stage patients were identified as having a Adult care need. Discharge occurred a minimum of 72 hours after this notice had been issued.**
- **Adult Services processed discharge notifications and ensured that the patient was discharged within 24 hours of this date.**

How was the performance assessed and how was it agreed which part of the system "owns" a DTOC?

Who "owns" a particular DTOC depends on the reason a patient was delayed:

A Awaiting completion of assessment.

This could include any assessment (by health and/or Adult Social Care professionals) of a patient's future care needs. Therefore delays could be due to either NHS, Adult Social Care or a combination of both.

B Delays awaiting public funding

All patients whose assessment was complete, but whose transfer had been delayed due to

- **awaiting Adult Services funding (e.g. for residential or home care), or**
- **NHS funding (e.g. for nursing care or continuing healthcare).**

This also included cases where

- **Adult Social Care and NHS had failed to agree funding for a joint package or**
- **an individual was disputing a decision over fully-funded NHS continuing care in the independent sector.**

C Delay awaiting further NHS care, including intermediate care

All patients whose assessment was complete, but whose transfer was delayed awaiting further NHS care. The main issue was normally capacity in rehabilitation.

This did not include delays in providing NHS care provided in the patient's own home, e.g. District Nursing support.

D Delay awaiting Residential/Nursing Home Placement/ Availability

All patients whose assessment was complete, but whose transfer was delayed awaiting a Nursing/Residential home placement, because of lack of availability of a suitable place to meet their assessed care needs.

E Delay awaiting domiciliary care package

This was the responsibility of the agency responsible for providing the service which was delayed. NHS input to a home care package might include the services of a district nurse or CPN, an occupational therapist or physiotherapist. The delay could therefore be Adult Social Care, health or shared responsibility

F Delay awaiting community equipment and adaptations

This was the responsibility of the agency responsible for providing the equipment. The delay could therefore be Adult Social Care, health or shared responsibility

G Delay due to patient or family choice

This covers all patients whose assessment was complete and who had been made a reasonable offer of services, but who had refused that offer. It would also include delays incurred by patients who would be funding their own care e.g. through insisting on placement in a home with no foreseeable vacancies.

Where Adult services are responsible for providing services and a place in a person's home of choice was not immediately available, they were offered an interim package of care. All interim arrangements were based solely on the patient's assessed needs. Only if no alternative was provided which could meet the patient's needs, would Adult Social Care be liable for reimbursement.

Where patients had been offered appropriate services, either on an interim or permanent basis, by the local authority but were causing a delay, the responsibility for discharging the patient rested with the acute hospital.

H Disputes

A dispute resolution process existed to deal with disagreements about where responsibility rested.

There was an expectation that DTOC would be minimised through the following steps:

- Discharge planning began on admission or in the early stages of recovery
- There were no built-in delays in the process of deciding that a person would no longer benefit from acute care and was safe to be transferred to a non-acute setting
- The NHS and Adult Services would jointly review policies and protocols around discharge, including handling of choice of accommodation; and had systems and processes for assessment, safe transfer and placement, as part of their capacity planning
- These steps should be guided by good professional practice and safe, person-centred transfer. Although an acute ward was not appropriate once an acute episode was over, joint planning was needed to ensure that appropriate care was available in other settings.

What was being done to improve performance?

Additional resources had been allocated to the Council's Hospital Discharge Team (HDT) throughout the winter to drive improvements to enable services to reduce pressures on BHRUT and provide effective on-going support for people in their own homes and to increase Adult Social Care work and administrative capacity to allow the Council team to work alongside ward-based discharge nurses. These included:

- An increase in Adult Social Care capacity to extend the hours that the team was on site at Queen's Hospital; the Team was working 7 days per week
- Continuing Adult Social Care support for the Community Treatment Team (CTT) working in A&E to redirect patients who may need Adult Services care rather than Health Care
- Enabling support for the delivery of formal notifications to speed up process
- Conducting evidence-based review of delays deemed as a result of decision making, with a commitment to change our process if issues are identified
- Developing and delivering an Adult Services care induction forward discharge staff to help team building and understanding of Adult Social care

- Working together to streamline processes and governance to avoid duplication and improve efficiency
- Working alongside all the Adult Services and health care economy
- Ensuring clear decision pathways and clear accountability to avoid confusion

There was commitment to working in partnership at operational and commissioning level to ensure services (increasingly non-bed based) were available to avoid admissions and enable earliest discharge for those who had been in hospital. This would also provide a solid evidence base for strategic decision making on future service arrangements.

The work being undertaken to improve performance contributed to Health and Wellbeing Board priorities for improving the care of vulnerable people, helping to increase independence, appropriateness of care services, increasing integration of care and improving wellbeing.

Performance

The actions being taken were expected to continue improving performance on DTOCs. By streamlining process, removing unnecessary processes, building community service capacity and investing in prevention the number of people who occupy hospital beds when they are medically fit to be discharged to another care setting would be reduced.

Havering Adult Social Care

Additional resources had been allocated to the Hospital Discharge Team during the winter period in order to drive improvements, to enable services to reduce pressures on BHRUT and to provide effective on- going support for people in their own homes.

As a result of this, there had been a reduction in the total number of DTOCs for BHRUT for 2013 by 50% in comparison to the previous year. It was acknowledged, however, that there were still some problems but these were caused in the main by the numbers attending A&E, which remained disproportionately high.

Barking, Havering and Redbridge University Hospitals Trust (BHRUT)

Work was continuing on the formation of the Joint Assessment and Discharge (JAD) Team involving the Clinical Commissioning Groups with the three London Boroughs (Havering, Barking & Dagenham and Redbridge). Current discussions were focused on IT and structures. The newly joined-up team would be working to the same pathways and processes but it was highly likely that it would take some time for the new system to become established. The JAD team could be in place by September 2014 but this was not definitive.

There was a backlog of assessments for elderly clients requiring NHS Continuing Healthcare. The CCG had been supportive and provided an additional member of staff, thus reducing the backlog from 28 to 11 cases. One main concern was the waiting times for specialist rehabilitation: this was in part due to insufficient bed capacity further impacted by inappropriate referrals. Many patients were taking up acute beds when they could be treated at home. This was currently being reviewed by the CCG who were investigating alternative pathways.

All patients being discharged to residential or rehabilitation homes were given choice, if they had capacity, and families were also consulted. There were legal processes and protocols in place that had to be followed. In the event of patients having no family, independent advocacy services would be involved in order to ensure that the hospital was acting in the patient's best interests and Best Interest Assessors were also based in the hospitals. Where patients had little or no capacity, they were still given access to advocacy services. The group were advised that the services of the Red Cross were still being utilised. The Department of Work and Pensions were contactable to ensure benefits were paid to the patient. If there were delays in families becoming involved, a discharge meeting in conjunction with Adult Social Care would be held if there were any issues to discuss – pending patient capacity. If the patient had no capacity, then historical evidence would be reviewed and advocacy services deployed.

More work was also being carried out around pharmacy prescribing and ways of auditing the process. Anecdotally, 50% of prescriptions arriving at hospital pharmacies were incorrect, thus causing further delays and there remained concern that money was wasted when elderly patients left hospital with newly-prescribed medicines when they already have supplies at home and likewise before being admitted to hospital. A GP Alignment Scheme had been introduced to assess and see all residents weekly in care homes and to review their medications, which had produced considerable savings.

The question of prescription errors and the processes to ensure patients' medication is not duplicated whether on admission or discharge were

being investigated.

North East London Foundation Trust/North East London Community Services (NELFT/NELCS)

Further work had been carried out with the Community Treatment Teams (CTTs) around rehabilitation beds, clinical effectiveness and quicker discharge. Two pilot schemes were running for six months: one looking at BHRUT direct referrals, the other at A & E attenders.

In addition to the opening of an additional 26 rehabilitation beds, winter pressure monies had been utilised in the Intensive Rehabilitation Service where patients were treated at home. Patients reported feeling better being in the home environment and patients generally had quicker recovery times when treated at home.

Thus far, 2000 patients had been seen by the CTTs, however, 80% did not require admission to hospital. Patient surveys were also showing very positive outcomes and that these had been forwarded onto the CCG and other governing Bodies.

There were three tiers within the District and Community teams:

- District Nurse
- Psychiatric Nurse
- Mental Health Nurse

Nurses within the CCT were available between 8.00 pm and 10.00 pm. It was acknowledged that agency nurses had been used during the winter pressure period, however, there was a new advertising campaign underway; nurse recruitment was currently at 85%. The CCG were currently assisting in the lead process looking at merging more services.

London Ambulance Service (LAS) referral rates were also being scrutinised. Patients and Carers were the highest groups in referral rates where 50% said that they would rather call the London Ambulance Service before anyone else.

Havering Clinical Commissioning Group (CCG)

The CCG and the Local Authority were working with providers about the Joint Assessment and Discharge (JAD) Team and IT and structure issues were still under discussion. The plans were still in the early stages and implementation would be complex. The JAD Team was an integral part of the Better Care Fund application for monies for Health and Adult Care that had been submitted to NHS England.

The CCG had provided 20 additional beds to the Intensive Rehabilitation Service, as well as extra staff.

Further work was being carried out with the CCTs on reablement. The CCG were looking at a "Collect and Settle" scheme where intensive support for patients was provided for a period of five days when they first left hospital. The scheme was currently in its infancy and costings had yet to be finalised but it was hoped to implement the plan later in the year.

The CCG was in the process of reviewing the Stroke Service.

4. The Role of Healthwatch Havering since April 2013

With the creation of Healthwatches, and their wider and more strategic role, it was important for Healthwatch Havering to utilise the new opportunities that the Health and Social Care Act 2012 provided, in particular membership of the Health and Wellbeing Board.

It was clear to us that the way to achieve a whole-system approach to changing the care for the frail and elderly in respect of acute hospital care was for the Health and Wellbeing Board to set the strategic priorities for the Borough. The power of working in partnership with the CCG and the Council at strategic level meant we could help to achieve sustainable and measurable change. The Health and Wellbeing Board established eight priorities, of which two directly relate to care of the Borough's frail and elderly residents:

- Priority 1 Early help for vulnerable people
- Priority 5 Better integrated care for the 'frail elderly' population

Havering faces a number of challenges, three of which are most critical when looking at the care provided for the frail and elderly:

- The Borough has the highest number of older residents in London and the fastest growing older population in London;
- a poorly performing acute hospital, currently placed in 'special measures', with severe difficulties in the management of the A&E department and London's highest ambulance delays on arrival at A&E, and a high number of admissions for patients over 60; and
- the healthcare system is described as one of the country's most 'challenged' systems

The approach taken has been to tackle the problem of poor discharge arrangements in a wider context so we asked questions such as:

1. How do we discover why so many frail and elderly patients are attending A&E?
2. How do we find out what the patients themselves think about being taken to A&E as the chosen method of care?
3. Can we tackle the problem from the 'front end' in a positive way, i.e. managing the frail elderly care better so that admission and the problems with discharge are substantially reduced?
4. Can we develop a whole systems approach across the 3 Boroughs that use Queens hospital to ensure that all residents get the best possible discharge arrangements and that there is parity and equity across the care system for patients and the staff?

With the strategy set by the Health and Wellbeing Board, the operational work was developed by the CCG and Adult Social care team. Both teams provided detailed reports and updates to the Board, all of which were given in public are available on the London Borough of Havering's website at http://democracy.havering.gov.uk/ieListMeetings.aspx?CommitteeId=374.

We have been involved in developing this work with the Urgent Care Board and the Adult Social care team.

Examples of the work undertaken to support the four questions

- A detailed report from the LAS on the attendance at A&E of the frail and elderly residents helped the Urgent Care Board to consider ways in which unnecessary admissions could be prevented, thus reducing the risk of poor discharge.

- Commissioning University College Hospital Partners (UCLP) to support all Health and Social Care providers to work together to gain a better understanding of each other's problems and the solutions for providing better care for the frail and elderly.

- UCLP undertook an independent audit of patient's views in the A&E (with Healthwatch Havering support) in September 2013

- The introduction of new community care clinical services aimed at supporting the frail and elderly in their own homes, or to facilitate an immediate discharge from A&E rather than admission. We co-produced the launch of the services (see our Report: ***New Services: Putting Care Closer to Home on 11th December 2013*** [available in hard copy from us or on our website])

- The new Community Treatment Team operates from 8am to 10pm seven days a week. Anyone can refer: self, family/friend/carer, GP, nursing home, by a simple phone call.

- The new Intensive Rehabilitation Service – 8am to 8pm seven days a week, accessed through the Community Treatment Team with direct access available to Queen's Hospital.

- We worked with UCHP to develop an animation for staff and the community on how to work together to avoid unnecessary admission to hospital.

- To ensure sound and comprehensive discharge planning, the leadership and the implementation was seen as so crucial that all commissioners and providers agreed there was a need to 'think outside the box'.

- A unique development, the Joint Access and Discharge Team (JAD), led by the three borough Councils to bring together staff from all disciplines to create one accountable team. This newly created, jointly-owned tri-borough team, which is in the final stages of pilot status, takes full responsibility for ensuring the co-ordination of discharge, seven days a week, for all the residents in the London Boroughs of Havering, Redbridge and Barking and Dagenham.

- A presentation by the Chief Executive of Havering Council at the Darzi forum on 3 July, setting out the achievements and providing measurable evidence of the improvements that have been made.

5. Conclusion

The work that began in 2011 with the LINk report started the process of recognising the importance of 'independent' organisations listening and translating the concerns that patients and their carers shared in order to improve the care of the frail and elderly patient. This work has continued since 2011 because of the on-going interest shown by the OSC in ensuring that discharge remained a high priority for all care providers.

With the creation of Healthwatch and Health and Wellbeing Boards a new emphasis has been placed on improving services. The care of the frail and elderly within our community has two clearly defined strategic priorities established by the Health and Wellbeing Board. The CCG has developed new services and recently acquired funds from the Prime Ministers Challenge Fund are to be committed to improving the discharge arrangements. The CQC Improvement Plans for Queen's Hospital include dedicated work on the A&E service and care of the Frail and Elderly patient. The JAD is a really innovative step forward to creating better, more effective and more personalised discharge planning care. Healthwatch Havering has been a key part of all of the work which has been developed in the last year.

Much work remains to be done and, whatever plans are made, discharge will always be an imperfect process because of the variables outside of the control of the families and agencies involved.

However, real progress is being made and – most importantly – as well as designing better models of care, there are support and training packages for the staff and combined organisational thinking on the new pathways, with external support to audit and validate the progress.

Participation in Healthwatch Havering

We need local people, who have time to spare, to join us as volunteers. We need both people who work in health or Adult care services, and those who are simply interested in getting the best possible health and Adult care services for the people of Havering.

Our aim is to develop wide, comprehensive and inclusive involvement in Healthwatch Havering. To achieve this we have designed 3 levels of participation which should allow every individual and organisation of the Havering Community to have a role and a voice at a level they feel appropriate to their personal circumstances.

We are looking for:

Lead Members

To provide stewardship, leadership, governance and innovation at Board level. A Lead Member will also have a dedicated role, managing a team of members and supporters to support their work.

Active members

This is the key working role. For some, this role will provide an opportunity to help improve an area of health and Adult care where they, their families or friends have experienced problems or difficulties. Very often a life experience has encouraged people to think about giving something back to the local community or simply personal circumstances now allow individuals to have time to develop themselves. This role will enable people to extend their networks, and can help prepare for college, university or a change in the working life. There is no need for any prior experience in health or Adult care for this role.

The role provides the face to face contact with the community, listening, helping, signposting, providing advice. It also is part of ensuring the most isolated people within our community have a voice.

Supporters

Participation as a Supporter is open to every citizen and organisation that lives or operates within the London Borough of Havering. Supporters ensure that Healthwatch is rooted in the community and acts with a view to ensure that Healthwatch Havering represents and promotes community involvement in the commissioning, provision and scrutiny of health and Adult services.

Interested? Want to know more?

Call our Manager, Joan Smith, on **01708 303 300**;
or email **enquiries@healthwatchhavering.co.uk**

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