Insights to inform a shift

From hospital to community

Live-In Care Following Hospital Discharge

Early Review Insights

December 2025

healthwatch Kent

INSIGHTS AT EK360

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About Us

Healthwatch Kent is your local independent champion for health and social care. Our aim is to improve services by ensuring local voices are heard – we want to hear about health and social care experiences so to influence positive change for communities across the Kent area. We have the power to make sure NHS leaders and other decision makers listen to your feedback and improve standards of care.

We use your feedback to better understand the challenges facing the NHS and other care providers, to make sure your experiences improve health and care services for everyone. It is really important that you share your experiences – whether good or bad, happy or sad. If you've had a negative experience, it's easy to think there's no point in complaining and that "nothing ever changes". Or, if you've had a great experience, that you 'wish you could say thank you'. Your feedback is helping to improve people's lives, so if you need advice or are ready to tell your story, we're here to listen.

Recently, the Government has announced plans to close Healthwatch England and Local Healthwatch as part of a wider effort to streamline patient safety and voice organisations across health and social care. Healthwatch will continue its important work—listening to the public and patients and using those insights to influence the future of NHS and social care—until changes to the Health and Social Care Act come into effect.

We recognise the significant transformation underway across the health and care system, and the challenges that come with it. As we look ahead, we remain committed to working with partners to explore new ways of ensuring people's voices continue to be heard. This commitment is a fitting legacy to our 12 years of independently amplifying the voices of Kent residents.

Healthwatch Kent is hosted by EK360.

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Introduction

This early review provides insights into the pilot implementation of a live-in care programme offered by East Kent Health and Care Partnership and Carers' Support East Kent following hospital discharge. Healthwatch Kent were commissioned by East Kent Health and Care Partnership to study the experiences of five patients, their carers (relatives or friends) and the Multi-Disciplinary Team (MDT) Leads who oversaw their care planning and transition.

The live-in care model provides patients with in-home support for two weeks post-discharge, as an alternative to residential care or standard home care packages. Through semi-structured interviews, developed into five case studies, this study explores how the live-in care model affected patient outcomes, discharge experiences and carers (relatives or friends) involvements.

With these experiences coming from the first few people to go through the pathway, some of the issues being shared were picked up as part of the refinement and development of the pilot.

Key Findings

Positive impact on patient recovery: Across all five cases, live-in care was instrumental in enabling safe, more supported hospital discharges. Patients reported regaining confidence, some reported regaining independence, with carers (relatives or friends) describing the arrangement as reassuring and effective.

Inconsistent communication: A significant concern across the cases was inconsistent or poor communication between hospitals, carers (relatives or friends) and care providers. Some carers (relatives or friends) were unaware of care arrangements until the last minute or learned of them informally, contributing to confusion and distress. Feedback in this area concerned the overall journey of patients and not just what was in the Live in Care pathway scope.

Variable carer (relatives or friends) involvement: The involvement of carers (relatives or friends) in discharge planning varied widely. While some were deeply engaged, others were marginalised or uninformed altogether. This variability influenced overall satisfaction with the discharge process from patients and their carers (relatives or friends). Again, reflections in this area were often wider than just the Live in Care pathway.

Challenges with live-in care worker matching: Though many patients developed positive relationships with their care workers, mismatches in expectations, training levels and communication skills sometimes hindered the experience. The opportunity for the patient to meet with their live-in care worker prior to discharge was found to be severely lacking.

Support for live-in care: Despite the challenges, all participants recommended the live-in care programme for other patients. The programme's perceived value lay in offering the opportunity for patients to return to their home with a humane, patient-centred approach to care.

Conclusion

The live-in care programme demonstrates strong potential to support a smoother, safer and more dignified return home for patients following hospital discharge. However, its long-term success hinges upon improvements to communication, patient and carer (relatives or friends) involvement, pre-discharge introductions between patients and live-in care workers and addressing the gaps in information-sharing between hospital teams, patients, carers (relatives or friends) and care providers. With refinement, the live-in care programme could improve outcomes and satisfaction for patients during their critical transition from hospital to home.

Recommendations

Within Live in Care pathway scope

1) **Introduce pre-discharge introductions with live-in care workers**
    - Support rapport building and reduce patient anxiety.
2) **Develop live-in care worker matching processes and training pathways**
    - Align live-in care workers with patient needs and provide consistent training.
3) **Clarify roles, expectations and practical arrangements**
    - Set clear expectations around routines, costs and live-in care worker responsibilities.
4) **Maintain a feedback loop for continuous improvement**
    - Regularly collect and act upon stakeholder feedback to improve service quality

Wider than the Live in Care pathway

1) **Strengthen the communication across the discharge pathway**
    - Improve the clarity and timeliness of communication between hospitals, patients, carers (relatives or friends) and care providers.
2) **Embed patient and carer (relatives or friends) involvement in discharge planning**
    - Ensure shared decision making is embedded in the discharge planning process.
3) **Ensure coordination with wider post-discharge services**
    - Ensure holistic wrap-around services necessary for patient recovery are built into the live-in care programme coordination.

Introduction

Following a pilot that took place in 2024, East Kent Health and Care Partnership are planning to have a soft launch of the *Better Lives Together* programme, "Live-In Care Following Hospital Discharge". The first attempt at delivering the programme came to an abrupt halt with a limited evaluation carried out when the provider ceased to work with the NHS.

To inform the programme moving forwards, East Kent Health and Care Partnership commissioned Healthwatch Kent to gather and analyse insights from five patients and their carers (relatives or friends) about their experiences of live-in care. Healthwatch Kent also spoke with the Multi-Disciplinary Team (MDT) Leads responsible for working with each patient and overseeing their live-in care planning and discharge from hospital alongside Carer Support Coordinators from Carers' Support East Kent.

Live-in care involves having a care worker live within the patient's house to provide in-home support. This arrangement allows patients to receive personalised care in the comfort of their own home for two-weeks after their discharge from hospital. The live-in care programme was a new offer to patients in 2024 and was trialled as an alternative to residential care homes. Live-in care is offered free of charge to patients, but requires an eligibility assessment before it is suggested as a discharge option.

We spoke to some of the very first people to go through the pathway and therefore some of the issues raised in this report were already picked up as part of the refinement and development of the pilot.

Methods

Procedure

Our study made use of semi-structured interviews with patients and their carers (relatives or friends) on their experiences of the live-in care programme. The interview questions were developed in collaboration with East Kent Health and Care Partnership, Carers' Support East Kent, Kent Community Health NHS Foundation Trust, East Kent Hospitals University NHS Foundation Trust and Adult Social Care. The conversational framework that was used with patients and their carers (relatives or friends) is provided in ***Appendix A***.

Semi-structured interviews were also carried out with Multi-Disciplinary Team (MDT) Leads responsible for working with each patient and overseeing their live-in care. The interview questions for MDT Leads were also developed in collaboration with East Kent Health and Care Partnership, Carers' Support East Kent, Kent Community Health NHS Foundation Trust, East Kent Hospitals University NHS Foundation Trust and Adult Social Care. The conversational framework that was used with MDT Leads is provided in ***Appendix B***.

Interviews with all participants were conducted between March – May 2025 and were completed via telephone calls or online using Microsoft Teams. Consent was obtained from all participants prior to interviews commencing. Interviews were recorded and transcribed upon completion.

Measures

Our study looks at two measures that were drawn from the aims of the Live-In Care programme:

1. Improving patient outcomes, i.e. patient confidence, functional ability, mobility and independence.
2. Include carers (relatives or friends) in the discharge planning process.

Sample Selection

A total of 12 participants took part in our study. This included patients that had undertaken the live-in care programme, their carers (relatives or friends) and the MDT Leads responsible for overseeing their care.

Recruitment of patients and their carers (relatives or friends) to the study was facilitated by East Kent Health and Care Partnership and Carers' Support East Kent.

Recruitment of MDT Leads to the study was facilitated by East Kent Health and Care Partnership and Kent Community Health NHS Foundation Trust.

Two patients were described by their carers (relatives or friends) as lacking the capacity to provide an interview for the study and so interviews with these patients were not obtained. Additionally, one MDT Lead was unavailable to provide an interview for their patient and so this interview was not obtained.

Assessment of Risk of Bias

The methodological quality of this study was evaluated using Cochrane's Risk of Bias Tool (ROBINS-E) for non-randomised studies (see: Higgins et al., 2024). This tool assesses bias across several domains including: confounding variables, participant selection and missing data.

Based on the assessment, this study was judged to have a low risk of bias, indicating that while residual confounding cannot be entirely ruled out due to the observational nature of the study, there were minimal concerns regarding bias in the results.

Analysis

Interviews were grouped together around each patient's experience of the live-in care programme and summarised into case studies to give details to the background, key issues or experiences and emergent themes of each case. Cross-case thematic analysis (see: Mills et al., 2010) was then used to interpret recurring patterns, tensions, contrasts and insights across patient's experiences.

All participant data was analysed independently of interviews being captured, ensuring that observations and interpretations were objectively drawn from the collected responses. To uphold the anonymity of participants, direct quotations have been edited wherever identifiable information is presented. Where edits of direct quotations have occurred, this is explicitly stated within the findings section of this report. Additionally, pseudonyms have been adopted wherever needed to avoid anonymising to the point of vagueness.

Findings

Patient A

Background

Patient A had previously lived semi-independently before their experience being admitted into hospital. Prior to the hospital admission, the patient had no mobility aids in place and was actively managing their own life, with some care support. Admission into hospital triggered a cascade of medical interventions including a stint in a rehabilitation unit.

Initially, plans for discharge included a traditional care package of three daily visits. However, following further hospitalisation, an Occupational Therapist (OT) offered an alternative option – a 24-hour live-in care package. This option, relatively new to both the patient's carer (relative or friend) and the service, was accepted with a mix of relief and uncertainty:

> ***Carer (relative or friend)*: "The OT from the hospital discharge team came and initially if [the patient] had been discharged…it was going to be carers three times a day… then [the OT] said, 'look there is this new system, this new scheme, I think you might be eligible'…that was the choice."**
>
> ***Patient A*: "I don't remember being given options. I was very grateful for whoever was going to help me… it was in their hands to decide what was best for me, which made me quite happy."**

The carer (relative or friend) of Patient A had not heard of this offer of care before but recognised that the traditional care model would not meet the patient's complex needs. The live-in option was accepted with the carer (relative or friend) recognising that it was an opportunity that was too good to turn down:

> ***"Firstly, I was amazed it was offered. And there was no way we're gonna refuse it unless [the patient] didn't want it…we thought it would be silly to refuse it… we thought it's a great thing."***

The carer (relative or friend) of Patient A felt the patient wasn't particularly confident in being discharged from the hospital and this was partly because of uncertainty about who was going to be living in the house with them. The carer (relative or friend) noted how it was not ideal that the patient and the care worker did not meet until they were all already in the house together:

> ***"Meeting the carer before you come home – that would have made a big difference. If [the care worker] had been able to visit at hospital, it would have made [the patient] more confident because [the care worker's] a stranger. I think for the family as well, to at least meet [the care worker] before."***

The Patient's Experience

Although the transition home was welcomed, the patient described feeling anxious at the time of discharge and unsure about the live-in care worker. The decision was taken in a moment of vulnerability for the patient who had little memory of the detail:

> ***"It was fine as far as I remember. I was in such a state, I wasn't even thinking about confidence. I was just grateful for anybody who did anything for me. It was fine, [the care worker] was fine."***

Patient A's condition meant that confidence in mobility was low, and the patient was concerned about falling again, saying ***"I can't say that I am confident that it won't happen again"***. Nonetheless, the patient appreciated the support they received and ultimately developed a good relationship with the care worker:

> ***"What I know of [the care worker] I like very much."***

The Carer's (Relatives or Friends) Perspective

Patient A's carer (relative or friend) was clear that a standard care package would not have been sufficient and appreciated the difference that the live-in care made. Some of Patient A's family lived far away, making regular visits difficult and the live-in care offer removed a potential burden of care:

> ***"It's made a big difference. [The patient] didn't want a nursing home…it was amazing when it was offered because it is needed. But we didn't think it was going to be there."***

However, the transition was not without challenge. The carer (relative or friend) felt the patient had little capacity to make complex decisions at the time and was particularly anxious about leaving the hospital environment:

> ***"It was really hard at that point for [the patient] to make any sort of decision… to give [the patient] the choice was too much for [them]… I would say that [the patient] didn't feel particularly confident coming back from the***

> ***hospital…very anxious initially, partly having not met [the care worker] but I think even if they had met, [the patient] would have been anxious.”***

There were concerns around communication, particularly when the care worker missed a critical instruction resulting in a health episode for the patient. The carer (relative or friend) acknowledged the intensity of the situation and recognised the challenges faced by the care worker:

> ***“It was a big responsibility, but then it is for a carer…I wouldn’t want to go and live with someone that I have never met before…[the care worker] was probably overloaded with the information we were giving [them] in an anxious moment where we’re all meeting each other for the first time and [the patient] was there. That wasn’t ideal.”***

Despite this, the relationship between the patient and care worker strengthened over time and the carer (relative or friend) expressed a positive overall impression of the service:

> ***“I would say [the patient] grew confident with [the care worker]. They seemed to have a good relationship and [the patient] didn’t want to let [them] go… I think [the patient] would recommend it.”***

The MDT Lead’s Reflections

The MDT Lead responsible for Patient A’s discharge planning described the process as efficient and well-coordinated. The patient and their carer (relative or friend) were engaged early and were open to the proposed offer. The team did not face capacity constraints and were able to act swiftly:

> ***“It was quite easy to do because obviously [the carer (relative or friend)] was present on the ward with the patient…so it was really easy, they were both very keen. Very keen to explore that option… It was really quick between the referral process and acceptance.”***

The MDT Lead noted how it was a therapist who saw and spoke with the patient and their carer (relative or friend), rather than the MDT Lead themselves. The therapist’s summation was that ***“it was going to be more appropriate to have [the patient] assessed within the home”***.

Although the MDT Lead noted the referral process could be improved by allowing direct contact with the live-in care broker (Carers’ Support East Kent), they described the overall experience as ***“easy”***, ***“smooth”*** and ***“effective”***:

> ***"It was a very good process for us. We literally did the referral form, handed over the information and then it was taken away right away. Yeah, it's very good… it's essential that we move quite quickly with patients and referrals. So, it did everything that we needed it to."***

Conclusion

Patient A's experience of discharge highlights the importance of appropriate and responsive care offers, especially in the context of complex medical needs. While the patient had limited capacity to engage in decision-making at the time, their carer (relative or friend) played a crucial role in supporting the transition home. The live-in care model provided a much-needed alternative to residential care and enabled the patient to return home safely.

Despite initial anxiety, the patient built a relationship with their care worker, and both the patient's carer (relative or friend) and the MDT Lead reflected positively on the process. The case underlines the value of involving carers (relatives or friends) in the discharge process, improving pre-discharge introductions with care workers and maintaining swift and seamless referral pathways that support the patient as much as the hospital.

Patient B

Background

Patient B had previously lived independently for many years but began receiving home care support around 18-months before being admitted to hospital. At the point of their discharge, the patient no longer had the capacity to live independently and so their carer (relative or friend) had taken over responsibility for making decisions on the patient's behalf. A decision was made to implement a live-in care arrangement for the patient's return home. The patient's carer (relative or friend) was initially presented with a choice between a care home and live-in care, but they felt the decision was ultimately made by the hospital team without their final consent:

> ***"I think [the patient] always wanted to stay at home and so I think we originally said yes [to] probably look at a live-in carer, but we'll think about it… I said we'll go home, and I'll talk to [the carer (relative or friend)] about it… When I went back to the hospital on the Monday…the decision [was] already made by them that we were gonna have the live-in carer."***

The carer (relative or friend) had hoped to take some time to consider the options and consult with one another over the weekend. However, when they returned to the hospital, they were informed that live-in care had already been arranged, and the patient was due to be discharged the following day. This left little time for the carer (relative or friend) to prepare the house or coordinate which was especially difficult as the carer (relative or friend) did not live locally.

> ***"[The patient] doesn't really have the capacity to make that decision so it was probably made by the team, I think. I was just a little bit taken aback…I had a phone call saying, 'we're coming today to look after [the patient]'. I just sort of said 'right well just a minute…I haven't really got that organised'. So that was a little bit of a shock. It did happen very quickly…but I didn't feel that we actually had made the final decision to do so."***

Despite the rushed nature of the discharge, the carer (relative or friend) acknowledged that live-in care may have been the best option to honour the patient's long-standing desire to remain at home:

> ***"I was happy to go along with it. I just obviously need a little bit more time to go and sort out the house and prepare for it really… I just think that's where [the patient] wants to be, that's where [they're] happy…[they've] been there for 50 years, it's [their] home."***

The Carer's (Relatives or Friends) Perspective

Although the carer (relative or friend) felt somewhat sidelined in the decision-making process, they reflected positively on the care provided. They described the live-in care worker as competent, caring and approachable. The care worker arrived several hours before the patient returned home which allowed for a brief period of handover and familiarity. Over the two-week period, the care worker supported the patient with day-to-day needs, including domestic tasks such as washing and ironing which also eased the burden on the family:

> ***"I think [the care worker] probably had quite a good understanding of what was going on and [the patient's] situation…for me, it was very good knowing that there was somebody there all the time. It was actually quite reassuring for us knowing that there was always somebody there if anything did happen."***

The care worker was entitled to a two-hour break each day, but they often chose not to take it. This took pressure away from the carer (relative or friend) who were concerned about how they would organise cover for those two-hour windows:

> ***"I was told the carer had to have two hours off a day…I just thought 'how am I going to organise that?' I didn't know how to organise it so basically, I did go down the next day after [the care worker] started so I could allow [the care worker] to go off for two hours. But [the care worker] said to me 'I don't do that. I never bother about going off for two hours. I'm quite happy'. And [the patient] wasn't that demanding…didn't really need a lot of extra care."***

Patient B was physically mobile and continued to move around the house and use the stairs. However, the carer (relative or friend) made it clear that they no longer felt the patient could manage on their own. The presence of a live-in care worker provided reassurance to them, even though the patient found it difficult to adjust to someone else living in their home:

> ***"[The patient] did not want to have somebody living in [their] house…made that very clear to me [and] kept saying 'are you taking [the care worker] away with you?' so definitely didn't like it."***

The care worker and carer (relative or friend) developed a good rapport, and communication was described as smooth and transparent. The carer (relative or friend) felt confident in the care being delivered and appreciated the additional support during what could otherwise have been a stressful transition period:

> ***"I felt confident…[the patient] had two weeks at home recuperating, really getting back to [their] old self so that was very good… I felt quite reassured and confident that [the patient] was being cared for."***

Reflecting on the experience, the carer (relative or friend) noted that while the process felt rushed and disempowering at the beginning, the overall outcome was successful. They felt the patient was supported and safe and that live-in care had allowed the patient to return to their home with dignity and continuity:

> ***"It did work out really well for us… As far as I am concerned, it was fine for [the patient]. I don't think there needed to be any extra to what was being done… I think it was probably a very nice way of getting yourself back into your house after you've been in hospital."***

Conclusion

Patient B's case demonstrated the complexities of decision-making when capacity is uncertain and time pressures limit collaborative planning. While the carer (relative or friend) was ultimately supportive of the care arrangement, they expressed disappointment at being excluded from the final decision. The rushed discharge and lack of preparation time added avoidable stress.

Despite these challenges, the live-in care offer was well received, and the care itself was regarded as professional, compassionate and effective. The carer's (relative or friend) confidence in the care worker, combined with their ongoing involvement, enabled a smooth transition and a positive recovery period at home. However, this case would have been improved by having the MDT Lead's reflections, though this was not possible to obtain. This case underscores the importance of communication and shared decision-making, particularly when patients lack capacity and carers (relatives or friends) must act on their behalf.

Patient C

Background

Patient C, a strong and independent individual who had no prior social care support, was admitted to hospital for surgery and rehabilitation following a period of acute illness. The clinical team had initially told the patient they would be discharged after a four-week inpatient stay. However, discharge was delayed, and the patient ultimately remained in hospital for eight weeks. The patient felt confused and frustrated at these delays and the limited communication surrounding them created a sense of disempowerment, leading to a strong desire to "escape" the hospital environment:

> ***"I've [been through] so many different departments for different things, and so many things that haven't been done and missed and God knows what else. Cancellations by the hospital that shouldn't have been made – much to say that I would not go back to [hospital] if you paid me a million pounds."***

Despite being medically cleared by their surgeon, the discharge was postponed by the therapy team leaving the patient feeling unheard and dismissed:

> ***"Originally, I was told that I was supposed to be out after 4 weeks – the surgeon gave me the 'all clear'. And in actual fact physio and whoever it is that is supposed to discharge you…said no."***

The prolonged stay placed a significant burden on the patient's closest family who faced a three-hour round trip to visit. Patient C's preferred option – to transfer to a hospital closer to home – was unavailable due to capacity constraints:

> ***"What I wanted was the package [to] take me to the local hospital then [my family] would have been able to get round to see me – it's only 8 minutes by bicycle."***

Patient C was ultimately offered a few discharge options including a 30-minute visit three times per day, or a care worker to live-in their home to provide around the clock care. They felt the options didn't reflect what they wanted or needed, particularly offering 30-minute visits three times per day:

> ***"For me to have someone for half an hour a day…was useless because I could not get in and out of bed. And this was the thing that stopped me coming out [of hospital] in the first place."***

The patient noted how they were supposed to have received physiotherapy each day of the week and hadn't done so, yet this was not reflected in their notes or in the decision to be discharged:

> ***"I only had a physio twice that previous week and that was only on a Zimmer Frame walking in and around the ward… They dismissed my comments, not in a nasty way. They said that according to their records I had had physio every day."***

Despite their initial reluctance, Patient C chose to take the live-in care option. They felt that whilst it was not their preferred option, it would at least allow them to return home:

> ***"I must admit that I am a very private person and independent…but it was the best way to get out of there."***

The Patient's Experience

Patient C's initial reluctance to live-in care stemmed from a desire for privacy and self-sufficiency. However, living with a full-time care worker proved to be both a challenge and a support. Patient C appreciated the presence of a supportive care worker, but struggled with the regimented routines put in place by the live-in model:

> ***"[The care worker] was at my door at 8am to get up and sometimes I didn't want to get up as I had had a late night and similarly in the evening [the care worker] was trying to get me to have dinner about 5 or 6 o'clock. I don't like to eat that early and sometimes I just wanted to relax and watch the television and stay up until 10pm."***

Despite this, Patient C noted how the care worker "was very good" and that they "reluctantly let me be as independent as I could", which the patient ultimately found to be very helpful in aiding their rehabilitation and regaining their independence. There were some challenges though, including adapting to having a new person in the home:

> ***"I found it very difficult to ask [the care worker] to do things, even though I couldn't do them. It was a problem for me because I am normally independent – it's not in my nature."***

Patient C did see the live-in care as a positive experience overall and would recommend it to others considering the option for their discharge:

> ***"Despite my reluctance to have someone else in my house, with it being someone that was helpful and I got on alright with – it was a big help to be***

> ***honest… If you were in the state that I was in I would say do it if you can. Because I couldn't even put my socks on…and couldn't get in and out of bed."***

The patient did express disappointment, though, in the lack thereafter of post-discharge physiotherapy support:

> ***"I was supposed to have two physio [sessions] a week…that didn't materialise – [the hospital] finally admitted that the paperwork hadn't been done after me chasing them a bit… I feel that would have helped tremendously with my recovery. In fact, I did pay out privately…and the improvement within a week was incredible."***

The Carer's (Relatives or Friends) Perspective

From the outset, Patient C's carer (relative or friend) expressed a high level of support for the live-in care offer, describing it as "absolutely great". While they acknowledged how new the live-in care offer was and highlighted initial reservations, they ultimately described the outcome as positive:

> ***"I felt relieved that someone was going to be with [the patient] 24-hours a day. As long as they got on, I felt completely confident. I think it is a great system."***

> ***"The only issues…is that it was a pilot scheme and we had never had experience of that before. You had to get used to someone actually living in your own home with you. But in the end that went down fine."***

Patient C's carer (relative or friend) also identified communication gaps within the hospital and that the discharge took a long time to materialise. These challenges made it feel as though the hospital were not considering Patient C's needs:

> ***"There was such a lot going on and I think [the patient] felt there wasn't the communication between everyone in the hospital. It didn't quite always happen, because [the patient] was promised something and it didn't materialise, it just kept going on… In the end [the patient] was there seven weeks which was a long time."***

Despite this, the carer (relative or friend) felt reassured knowing someone would be available to stay with the patient and recognised the benefits of the scheme in promoting safety and confidence during the patient's recovery:

> ***"It gave you confidence and it made you feel safe knowing that somebody was there… [The care worker] was great…was very polite and pleasant. I could not have asked for anything better really."***

Patient C's carer (relative or friend) was also keen to stress that they would recommend it to others considering the option for their family members who were waiting to be discharged from hospital:

> ***"I would say go ahead. It's a great service – I only hope that they can keep it up and continue with it."***

The MDT Lead's Reflections

The MDT Lead involved with Patient C reflected on both the systemic pressures and the rationale for offering live-in care. Post-COVID bed pressures and capacity constraints meant that timely transfers to community hospitals was not feasible. The team working with Patient C instead proposed live-in care as a way of enabling recovery at home in a more responsive and empowering environment:

> ***"We think…that's actually progressing [the patient] quicker than going to a community hospital ever would have. Because usually without the 24-hour care service, the largest care package we can do is a three-times a day. And if you're needing supervision to mobilise and you're having carers come three times a day, you have to sit and wait for the carers to come."***

The MDT Lead acknowledged the need for clear, compassionate communication in helping patients feel in control of their discharge plans:

> ***"When people come into hospital, they don't have any control over anything that's happening to them…the one thing that patients have control over is their discharge plans. I like to give people that little bit of freedom to make their own informed decision. Everyone's an expert in their own body and what they need."***

The live-in care offer was a new programme and unfamiliar to both staff and patients. The MDT Lead was keen to highlight how Patient C brought new questions that had not been asked during discharge before:

> ***"I remember [the patient] saying to me "will it be a male or female carer?". And I said "I don't know"…I don't know who they are or what gender they are or what age they are or what their background is. That's quite a daunting thing to say to somebody… I couldn't tell [the patient] and then [the patient]***

> ***asked me "what happens if I don't get on with them?"…it threw me a little bit. Because I'd never been asked that before…usually our care packages don't live with the person. So, it did throw me a bit."***

The MDT Lead highlighted the importance of involving carers (relatives or friends) in discharge planning to ease transitions and improve outcomes:

> ***"When you involve families in discharge planning a lot of the time…it makes the process a lot smoother…when you're explaining a process to a patient, sometimes they don't fully gather all the information in… When I speak to relatives, they can reiterate it in words that the patient really understands, in a way that they usually communicate with."***

The MDT Lead praised the efficiency of the referral process and noted the value of enabling independence in a home setting:

> ***"That promotion of independence and just being able to get somebody back into the home environment where they want to be, doing what they want to do…I think it comes back to a control thing. It's in their control, in their hands."***

The live-in care service was described in three words by the MDT Lead as "straightforward", "informative" and "encouraging". But the MDT Lead was keen to highlight how the system is often comparable to a conveyor belt:

> ***"We're waiting for [the hospital] to discharge somebody so they can take on of our patients and it's the same with rehab beds for somebody to be discharged…sometimes you could be waiting a day or so, sometimes you could be waiting one or two weeks. It's very variable."***

Conclusion

Patient C's experience of discharge from hospital and live-in care highlights the complexity of discharge planning and the critical importance of involving patients and carers (relatives or friends) in the decisions about care. Although Patient C initially resisted the idea of live-in care, the service ultimately enabled a safe and timely return home. Key to the success of the discharge was the patient's own determination to return home, the involvement of the patient's carer (relative or friend) and the responsiveness of the MDT Lead in adapting to evolving circumstances and discharge offers.

Patient C's case illustrates how integrated discharge planning can contribute to improving the outcomes and satisfaction for patients, even in the context of systemic constraints.

Patient D

Background

Patient D had experienced multiple hospital admissions over time, with the most recent stay resulting in the patient becoming desperate to get out of the hospital environment and to return home:

> ***"I just wanted to come home. I had been away from home for all that time, and I was fed up with the hospital, how I was treated."***

Patient D felt that they weren't given any options about their discharge or the type of care they would receive after leaving hospital. They also felt that the live-in care was decided for them and was based upon the fact that they already had other care in place:

> ***"They just wanted to get rid of me and get me out of hospital. I don't remember having any options… I think they just decided, you know, 'your time's up, out you go'… I didn't feel like I had much choice at the time because I had got other carers. And because I had put them on hold for the time being…[the hospital] didn't give me the option, they told me basically that someone was coming to live with me for two weeks. It was a new scheme apparently."***

Patient D felt alone during their discharge and that no one else had been involved in the planning process or in providing support for getting them back home:

> ***"It was just myself [involved in the discharge]. I don't have any family; I am totally alone… I had friends that came [to visit in hospital]; one particular [friend] who is very kind, [they] came here a lot. [The friend] wasn't any help in deciding what was going to happen because that seemed to be worked out for me. So, I didn't have any help at all."***

The negative experience whilst in the hospital and the lack of choice in the discharge process had left Patient D feeling annoyed and desperate to return to their home. The patient already had some care in place prior to entering into the hospital so felt 'slightly confident' about having a care worker live with them for two weeks.

> ***"…only slightly confident because I didn't know the person, I didn't know what was expected of them."***

However, when the patient returned home it transpired that the care worker had been sent to the wrong house:

> ***"When the ambulance pulled up outside my door, the carer that they had sent for two weeks was luckily there because they gave [them] the wrong address…luckily [the care worker] saw me."***

The Patient's Experience

Patient D found that the care they received was beneficial to them, but immediately found difficulties with understanding the care worker and sticking to a routine that had been built around the carer's hours of work:

> ***"It was good, [the care worker] did look after me. [They] were very caring, really nice… I found it difficult with the accent – understanding what [they] were talking about… [The care worker] told me [they] were on 8am till 8pm with two hours off in the afternoon. Well, I didn't want to go to bed at that time. So, [the care worker] would get me ready for bed, disappear and then come back about 9pm and make me go to bed. So, it worked alright. I said to [the care worker] 'why don't you go out for a walk?'. [The care worker] wouldn't go and stayed in the spare room all the time. There were a lot of times when [the care worker] wasn't doing anything."***

In spite of the language barrier, the patient adapted to the new routine and to having another person living in their home with them. By the end of the two weeks, Patient D felt "sorry to see [the care worker] go". Regardless of any issues, the patient felt their live-in care was beneficial to them:

> ***"[The care worker] was alright, it was the language that was the problem… I couldn't understand what [the care worker] was saying some of the time. [The care worker] was fine, I have no complaints about [them] at all. I was quite sorry to see [them] go… We never ate together. I was quite independent whilst [the care worker] was here. It was just the timing and the fact that there were times when [the care worker] was sitting in my dining room doing nothing."***

Patient D expressed upset at not having their mobility assessed before leaving the hospital as they were worried at how they would cope when back home.

> ***"I was terrified of falling. I'm using a Zimmer frame; I can't let it go … I do need more help walking. I practice up and down my hallway. It is helping a bit I suppose but not to where I want."***

Overall, Patient D didn't feel that much had gone well for them in their experience of hospital. But they described their experience with live-in care as "adequate" and did say that they would recommend the programme to others:

> ***"I would recommend it for two weeks. I am on my own, I don't want anyone living with me all of the time. [The care worker] was here for two weeks – it was good, because [the care worker] helped me to no end. I would have been stuck if I had just been dumped here by the ambulance, I wouldn't have been able to cope."***

Patient D was upset at their lack of physiotherapy as they felt this would have been beneficial to their recovery and improving their mobility when back in the house:

> ***"I didn't get much physiotherapy at all, that was my complaint with the hospital. I wanted to walk. [The hospital] took me one day, right near the end [of my stay]. I only had [physiotherapy] twice the whole time I was in that hospital. The first time…the lady in charge told us to do the 'Hokey Cokey'. And that was an absolute waste of time… I regret I didn't get any real physiotherapy at all. I just wanted to walk and get my legs stronger. That didn't happen."***

The MDT Lead's Reflections

The MDT Lead reflected on Patient D's experience in the hospital, suggesting that it may have been solitary and tedious for them:

> ***"[The patient] is registered blind and I think [they] were quite bored on the ward and every time I went to see [them], [they] weren't really doing anything… I think when I went to [the patient] it's almost like it got [their] brain working a bit and it provided that bit of input [the patient] needed."***

The MDT Lead also reflected on the patient's difficult experience in the hospital and how their discharge was continually delayed.:

> ***"Every time we tried to do something, [the patient] was not medically fit and then [the patient] was medically fit, and then wasn't again… I think that caused [the patient] a lot of frustration and every time it felt like I was ready to discharge [the patient], something happened that kind of stopped that… [The patient] actually was discharged when I was on leave. So, I came back and [the patient] was gone."***

The live-in care offer was arranged with the support of the patient's carer (relative or friend), who the MDT Lead described as being "very easy to contact" and "always at the end of the phone, ready":

> ***"[The patient's] next of kin are two friends and the friend that I was involved with most…went in and decluttered [the spare room] for the carer and made sure all the linens were washed…cleared all the old food out the home and got some fresh in… [The friend] set everything up ready for when [the patient] came home… [The friend] was very happy and thought [live-in care] was a great idea."***

There was confusion and a clear breakdown in communication as to whether the care worker needed to be paid for things such as food. This resulted in a back-and-forth exchange between the MDT Lead and Carers' Support East Kent before it was finally clarified that the patient was not required to exchange any money as all costs were covered under the live-in care budget. However, this clarification centred on the MDT Lead who expressed clear discomfort at speaking with a patient about money:

> ***"[The friend] asked about the money side of things, about the cost of having food and food budgets and this was one where we had a bit of confusion…I felt quite uncomfortable because I've never spoken to patients about money before… It's not something we do in the NHS and even if somebody dropped a few coins on the floor, you pick them up and you count them out with them and things like that. You always have to be very careful. So yeah, I felt very uncomfortable doing that."***

Patient D was offered live-in care by the MDT Lead because they had been "in hospital for a long time" and the MDT Lead was keen "that support for when [the patient] first went home with somebody that would be there to supervise…just in case anything did go wrong":

> ***"[The patient] was just so desperate to get out of hospital that [they] were just happy to have anything that was offered to [them]."***

The live-in care service was described in three words by the MDT Lead as "necessary", "relief" and "nice". Additionally, the partnership working with Carers' Support East Kent was described as "good". The MDT Lead was keen to highlight how because Patient D already had an existing care package, the live-in care was able to compliment this by being delivered around each other:

> ***"The live-in care and the private care package twice a day started on the same day. So, the team were able to setup so when the carer had their break in the day, [the patient's] private care package came in."***

Conclusion

Patient D's case highlights a significant discrepancy between the patient's experience of hospital and live-in care and the reflections of the MDT Lead involved in the care. While the MDT Lead believed that the patient's carer (relative or friend) had been closely involved in discharge planning and preparation for returning home, Patient D themselves expressed feeling isolated and unsupported and presented no knowledge of any carer (relative or friend) involvement in decisions affecting their care. This mismatch in perception underscores the importance of clear, consistent communication and a shared understanding of roles and support systems. Sadly, it was not possible to obtain an interview with Patient D's carer (relative or friend) which may have provided a further perspective on the processes and decisions that had taken place.

Despite the challenges encountered during Patient D's time in hospital, the live-in care arrangement ultimately provided a level of reassurance and stability for the patient. However, their sense of disempowerment throughout the process points to a missed opportunity to ensure the patient was not only kept informed but felt genuinely involved and supported in decisions about their care.

Patient E

Background

Patient E had lived independently before their hospital admission, which lasted for three weeks, with only light care support in place. Hospitalisation came as a distressing experience for both the patient and their carer (relative or friend). The carer (relative or friend) described the patient as resistant to receiving formal care and having strong views about retaining autonomy:

> ***"[The patient] just wanted to get out of hospital and didn't care [how]."***

During the stay, discharge planning was not clearly communicated to the carer (relative or friend). They were unaware that a live-in care worker had been arranged and only found out through informal conversations on the ward. The carer (relative or friend) recounted being told by a nurse that "no one had spoken to the patient" and were initially led to believe that the patient's comment about going home was a product of medication or confusion:

> ***"I asked if somebody had been along and spoken to [the patient]. 'No' they told me, 'absolutely not. [The patient's] on medication so probably imagined it; it might be [the patient's] way of getting out of hospital'…so that was that."***

A few days later, the carer (relative or friend) learnt that a live-in care package had been arranged. Despite the lack of consultation, the carer (relative or friend) recognised the pressure the hospital was under and the novelty of the care model being used. They were told repeatedly that the live-in care scheme was a new initiative designed to relieve bed pressure:

> ***"Two days later, when I went in, one of the nurses said, 'you know [the patient] is gonna be discharged with a live-in carer?' So, I said 'no' – anyway, they went through it that it was a very new thing. According to some of the staff at [the hospital] they had never done a placement like this before. Some of the nurses disputed this when I questioned it, but anyway. So that's how I found out really and I was told there was no other option…this was a way of freeing up a bed and getting [the patient] home."***

The carer (relative or friend) felt that the hospital was disorganised in the patient's discharge and the communication they received was not good enough:

> ***"Every question I asked, they kept telling me that it was a new scheme and apologised, so I didn't know anything about the care firm or anything. Eventually I did, but I don't think the communication was very good. But they***

> ***did say it's because it's not a thing that they're doing all the time, and they were struggling a little bit. If that's true, I don't know. But I wouldn't have said we were listened to."***

Although frustrated by the process, the carer (relative or friend) ultimately welcomed the discharge, acknowledging that the hospital environment had become deeply distressing for the patient:

> ***"I was always glad they were discharging [the patient] because [the patient] was so distressed every day… it was awful."***

The Carer's (Relatives or Friends) Perspective

The carer (relative or friend) described the initial transition home as disjointed, particularly around the arrival and preparedness of the live-in care worker. There were early concerns about the care worker's lack of initiative and limited training, which added to the carer's (relative or friend) uncertainty. The care worker reportedly relied heavily on being asked to perform tasks and was unfamiliar with basic household routines:

> ***"To me [the care worker] didn't have a clue what [they] were dealing with… [the family] did ask 'what training have you had?' and [the care worker] said 'none', and that came across… [the care worker] said they had a few online things and one of them was fire safety."***

> ***"After a couple of days, it was obvious that [the care worker] would only do what [they] were asked to do. [The care worker] never took the initiative to do anything – can you put the rubbish out? Can you use hot water? [The care worker] was washing up in cold water, all things that I would have expected not to have to go in and check."***

Despite these issues, the carer (relative or friend) acknowledged the care worker's kindness and willingness to support the patient when asked. Over time, things improved with some informal guidance:

> ***"It did settle down after I'd spoken to [the care worker] and said…'if you think [the patient] needs something, just do it'. [The care worker] was very young and very willing."***

The experience, while imperfect, provided peace of mind. The carer (relative or friend) highlighted the emotional comfort of knowing someone was always present:

> ***"It was a comfort knowing that someone was there… to know someone was with [the patient] for those two weeks."***

They felt the experience could have been improved by better matching care workers to patient needs and clearer communication from the hospital throughout the discharge planning process:

> ***"I just think had it been a different type of [care worker], a stronger [care worker] with a bit more experience I think it would have gone better."***

Nonetheless, the overall sense was that home was a better environment for the patient than the hospital, and the presence of a live-in care worker was a valuable support:

> ***"In terms of being home, yes it was 100% better [than in the hospital]."***

The MDT Lead's Reflections

The MDT Lead was not directly involved in this referral, which had been completed by a therapy assistant on the ward. They later contacted the carer (relative or friend) to ensure that they had been informed. The MDT Lead noted that live-in care was a relatively unfamiliar offer to many staff and that awareness of the scheme needed to improve:

> ***"This referral was actually completed by the ward themselves; it was by a therapy assistant…I wasn't involved in that initial decision making. That's why I phoned [the carer (relative or friend)] afterwards just to make sure that [they] were aware of everything."***

> ***"[The carer (relative or friend)] was so happy… I know [they] had multiple conversations with Carers' Support [East Kent]…[they] felt so included in [the patient's] discharge planning…over the moon, just so happy. And [they] had no concerns at all."***

Despite the process bypassing their direct involvement, the MDT Lead described the transition as smooth and well-supported by Carers' Support East Kent, praising the communication with the hospital and the carer (relative or friend):

> ***"Carers' Support [East Kent] are informing us of everything. They are constantly backwards and forwards with the next of kin, with us and with the carer that's going to go out and support the care."***

From a systems perspective, the MDT Lead saw the model as beneficial, describing the process as "easy", "prompt", and "fluid". They noted that it was aligned with what patients generally want – to return home – and acknowledged the benefits of an alternative discharge pathway that avoided institutional care.

Conclusion

Patient E's experience reflects the complexities of discharging patients with high care needs under system pressures. While the hospital's implementation of the live-in care model provided a much-needed exit from a distressing environment, poor communication with the carer (relative or friend) and a mismatch in care expectations created avoidable stress.

A lack of training and initiative from the live-in care worker left the carer (relative or friend) feeling frustrated. The carer (relative or friend) and the MDT Lead reflected positively on the value of the live-in care programme but noted areas for improvement including communication, care worker preparedness and patient-family consultation.

The case underscores the importance of involving carers (relatives or friends) meaningfully in discharge planning. Matching the care provision to patient personality and needs could have improved the experience for the patient and their carer (relative or friend). And ensuring communication is maintained from all aspects of the programme (discharge, care provision and ongoing progress) could improve the future implementation of live-in care services.

Cross-Case Thematic Analysis

From the five case studies presented in this report, the following themes have been identified that cut across each and highlight the effectiveness and impact of the live-in care programme.

Role of Carers (Relatives or Friends) in Patient Discharge Planning

Carers (relatives or friends) often acted as crucial advocate, decision-makers or support systems for patients, but their involvement varied significantly across cases. In some cases, carers (relatives or friends) played an active and central role in the discharge planning process. In others, carers (relatives or friends) were marginalised or excluded altogether.

Active and Central:

- Patient A and Patient C had carers (relatives or friends) who played pivotal roles in decision-making and transition support. Patient A's carer (relative or friend) even made logistical arrangements and advocated for what they felt was the best care for the patient.
- Patient C's carer (relative or friend) was instrumental in reinforcing decisions, offering reassurance and expressing clear support for live-in care.

Marginalised and Excluded:

- Patient B's carer (relative or friend) felt bypassed when the hospital made decisions without their final input, despite acting as the main decision-makers due to the patient's lack of capacity.
- Patient E's carer (relative or friend) found out about the discharge plan informally and after actions had been taken, feeling neither consulted nor listened to.
- Patient D's carer (relative or friend) was reportedly not engaged in decision-making, though the MDT Lead believed otherwise, highlighting a disconnect in the perception of the process.

The variability in the carer (relative or friend) involvement reveals inconsistent communication practices and decision-making transparency. Success for individual patients often hinged on how informed and involved their carers (relatives or friends) were.

Relationship Between the Patient and Live-In Care Worker

The patient-care worker dynamic emerged as a vital element of the programme, yet was shaped by personal compatibility, clarity and communication. For some patients, the relationship was positive and reassuring. For others, it was challenging or tense.

Positive and Reassuring:

- Patients A, B and C all reported warm, or developing positive, relationships with their care workers.
- Patient A's relationship evolved from one of anxiety to appreciation.
- Patient B's carer (relative or friend) was vocal in their praise for the care worker's approachability and presence with the patient.

Challenging or Tense:

- Patient D appreciated the care, but struggled with communication due to a language barrier and the rigidity of routines.
- Patient E's care worker lacked initiative and training, causing initial frustration. However, this slowly improved with guidance from the patient's carer (relative or friend).

A good relationship between the patient and care worker fostered trust, independence and satisfaction. Mismatches in personality, expectations or language skills could be seen to undermine this bond and ultimately affect the recovery of the patient. Critically, none of the cases reported a matching of compatibility between patient and care worker. This is underscored by some cases lacking any meeting between the patient and care worker until the patient had already returned home and the care worker already in place.

Communication Between all Agencies (Hospital, Patient, Carer (Relative or Friend), Care Provider)

Communication breakdowns were among the most common and critical issues identified across all five cases. These ranged from confusion as to whether care workers required payment, to carer's (relatives or friends) not being told the patient would be receiving live-in care until they were already being discharged from the hospital.

Poor Communication:

- Patient B and Patient E's carers (relatives or friends) were not fully informed or consulted before live-in care decisions were enacted.

- Patient C expressed deep frustration at hospital delays and contradictory information.
- Patient D experienced inconsistent messaging, with confusion about payment for care workers. They also experienced confusion about the input towards their discharge, believing to be alone and unsupported.
- Even when MDT Lead's believed that communication had occurred (e.g. Patient D), patients/carers (relatives or friends) often felt otherwise.

Smooth Communication:

- Patient A's MDT Lead and carer (relative or friend) described a relatively smooth process, highlighting early engagement and clear planning.

The effectiveness of the live-in care programme is undermined when patients and carers (relatives or friends) feel excluded or misinformed. Even where live-in care was ultimately beneficial, communication gaps led to anxiety and mistrust.

Live-In Care Programme Offering Reassurance

Despite implementation issues, the live-in care programme was generally recognised as a reassuring and supportive presence for patients during the transition home. There were limitations and caveats, as would be expected of any new service, but patients and their carers (relatives or friends) were clear in their appreciation for the live-in care programme and what it brought to the patient's stability in recovery.

Reassurances:

- The carers (relatives or friends) of Patients A, B, C, D and E all acknowledged the comfort of having someone present with the patients on a 24/7 basis for the two weeks.
- Patients A, C and D expressed gratitude for the help with tasks they could not manage alone, even if reluctant to accept the help at first.
- Every case ended with a recommendation of the live-in care programme.

Limitations and Caveats:

- Patient E's experience was undermined by their care worker's observed lack of training and experience.
- Patients C and D struggled with strict routines and preferred more autonomy.

- Patients C and D were disappointed by insufficient post-discharge physiotherapy, showing that reassurance from live-in care doesn't fully substitute for breakdowns with other essential support services.

The live-in care programme met a vital need and was appreciated across the cases. However, it's reassuring effect is maximised when paired with skilled care workers, robust supplementary services (e.g. physiotherapy) and complete communication.

Summary

Across the five case studies, live-in care was generally viewed as a positive (even essential) service that enabled patients to return home with dignity and support. However, its successful delivery depended on early and clear communication, meaningful involvement of carers (relatives or friends), a fitting matching of care workers with patients and responsiveness to the patient's emotional and physical needs. These cases illustrate that live-in care is not just a logistical solution, but a deeply relational and communicative process requiring coordination at multiple levels.

Conclusion

This early review of the live-in care programme, based on five individual case studies, offers valuable insights into the lived experiences of patients, carers (relatives or friends) and healthcare professionals. It illustrates the shift towards an accessible and integrated care built into local communities, a shift that is a core component of the 10 Year Health Plan for England (GOV.UK, 2025). Whilst each case presents unique circumstances and the complexities of each patient's discharge from hospital, there were a few consistent themes that emerged.

The live-in care programme was broadly viewed as a positive service often enabling a smoother, safer and more dignified return home following hospital discharge. For many patients, the presence of a full-time care worker alleviated anxiety, promoted independence and reduced the risk of readmission. Carers (relatives or friends) also expressed reassurance and gratitude for the care provided.

However, significant variability was observed in how discharge decisions were communicated and coordinated. Inconsistencies in patient and carer (relative or friend) involvement; gaps in information-sharing between hospital teams and patients, carers (relatives or friends) and care providers; and limited opportunity for pre-discharge introductions with care workers were all recurring concerns. These issues sometimes led to confusion, distress or a perceived lack of autonomy for patients and carers (relatives or friends).

Despite these challenges, all five cases concluded with positive reflections on the live-in care experience. This suggests that, when implemented with effective communication and collaborative planning, the live-in care programme has the potential to improve outcomes and satisfaction during the critical transition from hospital to home.

Learnings & Insights

While these insights are only based on a small and non-representative sample of patients who have engaged with the live-in care programme, the following broad recommendations are proposed to support the ongoing development and refinement of the service and one of the three key shifts outlined in the 10 Year Health Plan for England (GOV.UK, 2025): the shift from hospital to community care:

Specific to the Live in Care Pathway

1) Introduce pre-discharge introductions with care workers

- Wherever possible, patients and carers (relatives or friends) should meet their live-in care workers before discharge. Even a brief introduction can ease uncertainty, improve compatibility and help establish early rapport.

Actions/response

Face to face introductions were trialled but were logistically difficult. Now each person is offered a video call introduction with their care worker.

2) Develop care worker matching processes and training pathways

- Matching care workers to patient needs and preferences (e.g. gender, communication style, experience) may improve satisfaction and outcomes.
- Additionally, consistent training for care workers (particularly those new to the role) can ensure a standard level of care and confidence.

Actions/response

Focus on care worker matching continues – a "this is me" resource about the person in receipt of care to help support the matching process is going to be developed.

3) Clarify roles, expectations and practical arrangements

- Clear guidance on roles (e.g. care duties, daily routines, breaks) and practicalities (e.g. house arrangements, costs covered under the live-in care package) should be shared with all parties. This can help prevent misunderstandings and support smoother transitions.
- Additionally, including expectations around 2-hour breaks for live-in care workers can ensure live-in care workers are not expected to forego their entitled time away

from caring responsibilities. This is particularly pertinent for carers (relatives or friends) that are unable to fill in for these windows of time.

Actions/response

Updated patient leaflet is being developed to help give patients and their families/friends information about what Live in Care is and what to expect .

Queries about costs/food arrangements have been resolved. There was never a requirement for this to be paid by the person receiving the care but it was removed from the guidance for referrers early after being identified as a source of confusion.

4) Maintain a feedback loop for continuous improvement

Ongoing feedback from patients, carers (relatives or friends), care workers and MDT Leads should be routinely gathered and used to inform service development. This will help identify areas of strength and those requiring adjustment.

Actions/response

Case studies are being reviewed periodically to see where there is opportunity for learning, improvement and refinement of the pathway.

There is also a value for money review being undertaken.

Wider than the scope of the Live in Care pilot

1) Strengthen the communication across the discharge pathway

- Clear, consistent and timely communication between hospital teams, patients, carers (relatives or friends) and care providers is essential.
- Ensuring all parties are well-informed can reduce anxiety and increase trust in the care being offered.

Actions/responses

Visits to the referring teams (RTS and TADs teams on all sites) have been undertaken to ensure they remain sighted on the updated criteria and guidance and on-going development of the leaflet. These were repeated and there is a plan to repeat. There is also going to be a short video developed that can be used by teams to understand the pathway.

2) Embed patient and carer (relative or friend) involvement in discharge planning

- Patients and their carers (relatives or friends) should be actively included in decisions about care options, even when capacity is limited.
- Early conversations and shared decision-making can support more personalised, empowering discharge experiences.

3) Ensure coordination with wider post-discharge services

- Live-in care should be complemented by timely access to those additional support services (e.g. physiotherapy) that have been identified for patients and coordinated to ensure holistic recovery is in place.

Actions/response

An escalation Standard Operating Procedure (SOP) to provide the MDT with clarity of escalation points if the Live-in Care arrangement breaks down or the person's needs change and an alternative pathway is required i.e. Community Hospital, KCC In-house Assessment Bed or Pro-active Assessment Unit.

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Appendices

Appendix A – Patient/Carer (relative or friend) Conversational Framework

Patient/Carer (relative or friend) conversational framework:

Introductions
Reaffirm consent is in place.

Patient/carer (relative or friend) involvement:

1. When you were in hospital were you given options about care after leaving hospital? (yes/no)
    1a. What options were you given? (e.g. staying for longer, care home, nursing home, Live-in care)
    1b. What did you want?

2. Did you feel listened to? (yes/no)

3. Were your relatives or friends involved in the planning process, how so? (how much involvement/what type of involvement/was this welcome)
    3a. What options were you given? (e.g. staying for longer, care home, nursing home, Live-in care)
    3b. What did they want?
    3c. Did they feel listened to?

4. How confident did you feel leaving the hospital knowing you had live-in support care in place? (not confident at all, slightly confident, confident, very confident, *completely* confident)

Communication and support outside of the hospital:

1. Once you left the hospital and you were home, how would you describe the support you received from the care worker?

2. Did you feel you could ask for changes to the support your live-in care worker gave you? How did this make you feel?

3. Were you kept informed of changes to the support your care worker provided? How did this make you feel?

4. What could be better about the communication or support you received from the care worker within your home?

Functional ability/mobility:

1. Was your physical health assessed as part of your discharge process, how so? (balance, mobility, muscle strength and co-ordination/ falls assessment?)

2. How confident did you feel in your own levels of ability and mobility? (not confident at all, slightly confident, confident, very confident, *completely* confident)

Independent living:

1. Were you living independently before you went into hospital? (yes/no) Yes – if so what support (if any) did you have in place? (care package/family support)

2. How did you feel about being offered live-in care?

3. What, if any, difference has having live in care meant to you? (your physical health and wellbeing)?

4. What, if any difference has it meant to you going back to your own home after being in hospital?

5. Would you feel confident to live independently again? (not confident at all, slightly confident, confident, very confident, *completely* confident)

Summary:

1. What went well for you?

2. What could have been better?

3. What would you say to someone else thinking about having Live-in Care after hospital discharge?

Appendix B – MDT Conversational Framework

MDT conversational framework:

Introductions
Reaffirm consent is in place.

Looking to increase knowledge on context and background to better shape these questions, including: a) were there any seasonal pressures; b) capacity pressures; c) better understanding of the pathway (levels of confidence about the pathway – how was it working with CSEK)

Improving patient outcomes:

1. What worked well in terms of involving patients in their discharge planning?

2. What challenges were involved?

Inclusion of carers:

1. What worked well in terms of involving family and relatives in discharge planning?

2. What challenges were there in involving family and relatives?

3. What if anything, would make it easier for clinical staff?

Process:

1. What was the process like from staff perspective? (did you understand what was needed?)

2. Please can you summarise in three key words?

3. Please describe your experience of the partnership working involved in this pathway? (What is the relationship like with Carers Support East Kent?/RTS/family/management etc)

If you would like to chat with us about the report you can reach us through the following routes:

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Online:
www.healthwatchkent.co.uk

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By Email:
info@healthwatchkent.co.uk

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Text us on 07525 861 639. By texting ‘NEED BSL’, Healthwatch’s British Sign Language interpreter will make contact and arrange a time to meet face-to-face

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