Accelerating Reform Fund Programme 2024-2025

Report & Recommendations

Delivering innovation
across Worcestershire
for unpaid carers

Carers are the golden thread

Carers
& Communities
Navigating Life's Journeys

Contents

Executive Summary

The Accelerating Reform Fund (ARF) provided Worcestershire with the opportunity to test and scale an innovative, system-wide approach to improving outcomes for unpaid Carers, with a particular focus on hospital discharge pathways.

Unpaid carers are a critical yet often under-recognised part of the health and care system. Locally, there are over 52,000 Carers in Worcestershire, yet only 29% are currently known to support services. Nationally, unpaid care is estimated to contribute £184 billion annually to the UK economy. Despite this, only 14% of Carers report being asked about their ability and willingness to care during hospital discharge processes. The implications for discharge flow, readmissions, Carer breakdown and health inequalities are significant, if Carers are not identified and involved at the eariest opportunity.

Programme Focus

Worcestershire's ARF Carer Programme focused on three key areas:

- Embedding Carer involvement in hospital discharge.
- Improving identification of unpaid Carers across systems.
- Introducing Technology Enabled Care Solutions (TECS) to support Carers at discharge.

Delivery was led through a strong partnership model between the Local Authority, ICB, NHS Trusts, and VCSE partners, with Carers & Communities (C&C) providing specialist leadership grounded in lived experience.

Method and Approach

The programme adopted a real-time ethnographic approach, supporting 67 Carers across stroke, frailty, acute, and community discharge pathways. By "walking the journey" alongside Carers before, during, and after discharge, the programme generated a depth of insight not previously captured locally.

This approach provided a proof of concept that embedding lived experience within health and care system redesign produces actionable intelligence and evidence that improves discharge planning, strengthens partnerships, and highlights the gap between policy intent and frontline delivery.

Summary Key Findings

- Carer identification remains inconsistent and significantly below expected levels.
- Only 27% of the 67 Carers felt their own needs were considered during discharge planning.
- There is a clear disconnect between strategic policy and operational practice.
- Carers are frequently perceived as barriers to discharge, rather than partners in care.
- Small, targeted changes within pathways can have a positive system impact.
- Carers experience significant health inequalities, financial strain, and increased caring intensity post-discharge.

Executive Summary : continued

Technology Enabled Care Solutions (TECS) Impact

The introduction of TECS at the point of discharge demonstrated measurable improvements in Carer confidence and resilience:

- 66% of Carers with TECS reported feeling confident and prepared.
- 58% reported being able to maintain their own health and wellbeing.
- 25% of Carers reported being able to remain in employment due to TECS support.

TECS proved particularly beneficial for new Carers and those managing increased caring responsibilities. The findings indicate that TECS should be embedded as a standard component of discharge planning, supported by earlier identification and clearer communication.

Programme Impact and Legacy

The ARF Programme has:

- Strengthened system partnerships across health, social care and the VCSE.
- Embedded Carer voice at operational and strategic levels.
- Established a qualitative evidence base linking discharge practice to carer and patient outcomes.
- Increased recognition of Carers as a population health inequality group.
- Demonstrated a scalable model for real-time system testing and improvement.
- Developed an evidenced based service specification which can be implemented across different discharge parthways and conditions.

Strategic Direction

To fully realise the benefits of this work, the system must now move from insight to implementation. Key priorities include:

- A standardised, system-wide approach to Carer identification.
- A dedicated Carer offer embedded within discharge pathways.
- Executive-level endorsement of Carers as equal partners in care.
- Implementation of a Carer Dashboard for performance oversight.
- Integration of Technology Enabled Care Solutions, for Carers as part of routine discharge practice.

The ARF programme provides clear evidence that improving Carer identification, involvement and support is not an optional enhancement, but a system necessity. If health and care reforms such as Home Before Lunch and Hospital to Home are to succeed sustainably, Carers must be recognised and supported as the golden thread running through discharge, recovery and community care.

The Programme recognises the sustained and unprecedented pressures currently facing the NHS, both now and in the future. Acute and community services are operating within high demand, workforce constraints, financial challenge and increasing clinical complexity. Despite this, staff continue to demonstrate extraordinary professionalism, resilience and compassion in delivering safe care.

Executive Summary : continued

This project has been developed within the context of these challenges. It is important to emphasise that the findings and recommendations set out in this report are not about attributing blame. Rather, they reflect a shared ambition and opportunity to strengthen discharge pathways, improve sustainability, and ensure Carers are better supported alongside clinical teams who work tirelessly to support their patients.

Behind every discharge is a family adapting to change, often at pace. Behind every hospital bed is a multidisciplinary team balancing flow, safety and quality. This programme has consistently highlighted that discharge sustainability is a shared responsibility — one that depends not only on clinical readiness, but also on Carer capacity, confidence and resilience.

Thanks

We would like to extend our sincere thanks to Worcestershire County Council for including C&C in the conversation from the outset and having the confidence in the organisation to lead and project manage the Carers element of the Worcestershire ARF Programme. We would also like to extend our thanks to the many colleagues across health and social care who contributed their time, expertise and commitment to this programme. Without their collective effort, the work would not have mobilised at pace or sustained its momentum. Their shared recognition of the value and importance of Carers, and the critical role they play within the system, has been fundamental throughout. Their commitment to true partnership working to find solutions to shared goals has underpinned the entire programme and been a significant contributor to its success. We are especially grateful to the colleagues below.

Integrated Stroke Services – Evesham Hospital (Herefordshire and Worcestershire NHS Health and Care Trust)

Sarah Hudson, Integrated Stroke Services Lead
Occupational Therapists
Physiotherapists
Ward Matrons and Nursing teams

Wyre Forest Ward – Kidderminster Hospital (Herefordshire and Worcestershire NHS Health and Care Trust)

Jane Thomas
Joanne Roberts
Joseph Mellish-Fisher
Lynn Dodd
Occupational Therapy team

Acute Frailty Ward – Worcestershire Royal Hospital (Worcestershire NHS Acute Trust)

Dr Debajyoti Paul
Raymond Padilla
Ward staff and multidisciplinary team

We also recognise the contribution of partners supporting the development and delivery of this work, including the Social Care Institute for Excellence (SCIE) and the Programme Management Group (PMG), whose oversight and guidance have helped shape the direction and integrity of the programme.

Across all teams, we are grateful for the generosity, openness and honesty shown in enabling us to work alongside services. The insight, constructive challenge and shared commitment demonstrated have ensured this work is grounded in real experience and practical system understanding.

By working collaboratively, transparently and without blame, we can continue to build pathways that are not only efficient, but compassionate, sustainable and resilient — for patients, Carers and the wider health and care system.

Introduction to the Accelerating Reform Fund

The Accelerating Reform Fund (ARF) is a groundbreaking initiative launched by the Department of Health and Social Care (DHSC) in 2024 to enhance quality, accessibility, and sustainability within Adult Social Care (ASC). It forms a key part of the government's wider People at the Heart of Care reform agenda, which aims to create a modern, fair, and person-centred care system across England.

Through a £42.6 million investment for 2024-2025, the ARF supported local authorities to test, scale, and share innovative approaches that can accelerate system-wide improvement. The fund focuses on three national objectives:

1. **People have choice, control, and support to live independent lives.**
2. **People can access outstanding quality and tailored care and support.**
3. **People find adult social care fair and accessible**.

The Social Care Institute for Excellence (SCIE) were appointed by DHSC to provide support to 120 ARF programmes across the country. Their role included training to identify local issues and challenges, embedding co-production principles, and facilitating peer learning and shared practice through national Communities of Practice. This support has been invaluable to the Worcestershire programme, enabling robust planning and reflection from the outset, ensuring that learning from Carers lived experiences is captured, and that evidence is built around innovation which can drive better outcomes.

Local authorities were invited to form regional consortia – working collaboratively with NHS partners, voluntary and community sector organisations, and people with lived experience-to deliver on two or more ARF themes, one of which had to focus specifically on supporting unpaid Carers. Funding bids were submitted in early 2024, and in April 2024, the joint bid from Herefordshire and Worcestershire County Councils was successful.

Introduction to the Accelerating Reform Fund : continued

Worcestershire's Local Priorities

Building on existing strengths in partnership working and community engagement, Worcestershire identified several local priorities to shape its ARF programme:

Empowering people to have greater control over their care options, including through digital tools to self-direct support and communicate their needs and preferences.

Developing and expanding volunteer-supported pathways for people drawing on care and support.

Embedding Carer involvement in the hospital discharge process, ensuring unpaid Carers are recognised at the earliest opportunity and supported at key transition points.

Improving identification of unpaid Carers across local systems and frontline services.

Encouraging self-recognition among Carers, increasing awareness and access to Carer support services.

To deliver this work, Worcestershire County Council invited Carers & Communities (C&C), previously Worcestershire Association of Carers (WAC) to lead and project-manage the Carer element of the programme. This partnership approach recognises C&C's expertise and strong history of delivering support to Carers and commitment to collaboration, ensuring that co-production, lived experience, and evidence-based innovation remain central throughout delivery.

The following table outlines the specific areas of focus for Worcestershire's ARF Carer Programme and how these initiatives aimed to create lasting improvements in how Carers are identified, involved, and supported across the county.

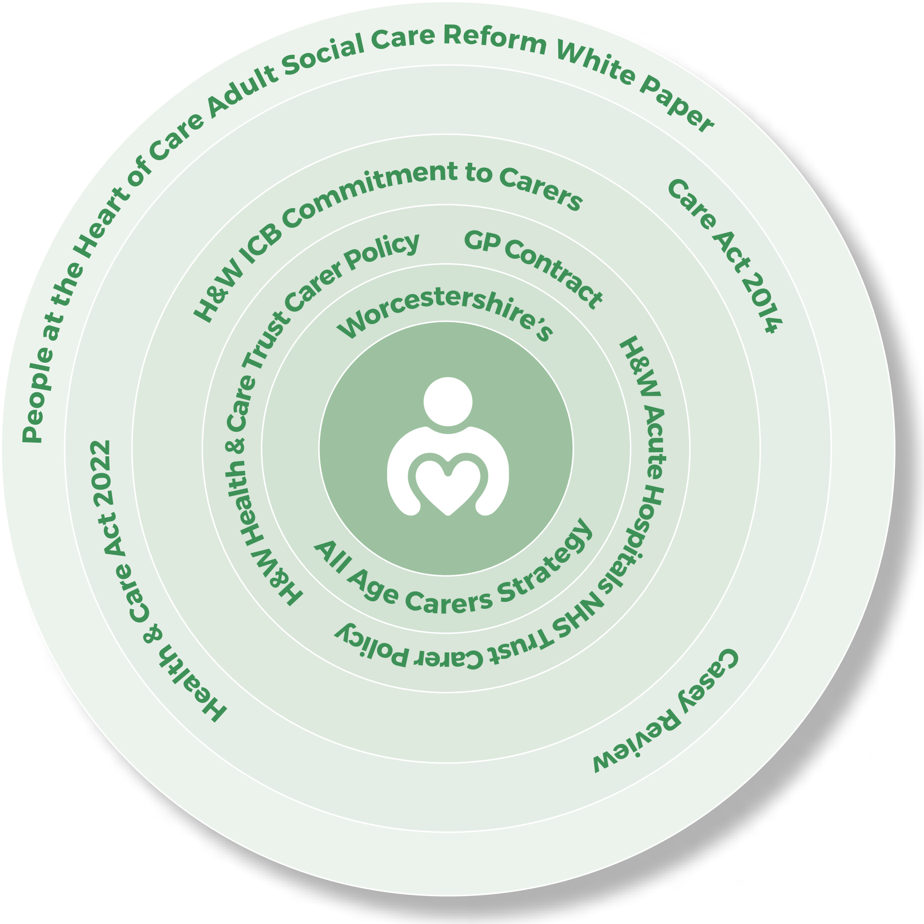
Hospital Discharge	Carers feeling supported & empowered through and beyond the hospital discharge process to ensure they are confident and have the right resources to support their loved one once they return home from hospital. To include Assistive Technology.
Digital	Ability to make informed decisions about their caring role through digital solutions.
Data Intelligence	Utilising data to identify unpaid Carers, understand their needs and circumstances and provide real time intelligence to inform service development and impact.

Landscape & Carer Stats

Understanding the context in which Carers operate is essential to assessing the impact of a rapidly changing health and care system. These changes are often experienced by Carers with little or no opportunity for input or influence. Since the start of the ARF Programme, several significant developments have been introduced that directly affect Carers. Locally, this includes the establishment of the Home Before Lunch initiative, alongside wider system reforms such as the Three Big Shifts, including Hospital to Home, and will include any recommendations from the Casey Review.

While these developments are important for improving patient outcomes and managing patient flow, they will have lasting implications for Carers. Their experiences and needs must therefore be actively considered if these reforms are to be fully realised.

Landscape & Carer Stats : continued



The wider impacts that Carers face every day

The long-term picture shows a clear shift from fewer people providing light care to more people providing intensive, complex care, alongside strong evidence that future demand will rise significantly. At the same time, the number of older Carers has increased sharply, with those aged 65+ nearly doubling in recent years, reflecting wider demographic change.

This is already translating into higher need: adult social care demand is projected to increase by around 50% by 2038, and nearly 1 million additional unpaid Carers may be required within the next decade. Rising levels of chronic illness, disability, and unmet need are key drivers, with unpaid Carers increasingly filling gaps as formal services come under pressure.

Forthcoming reforms, including the Casey Review and the NHS 10-Year Plan, are likely to reinforce these trends. A continued shift toward prevention, community-based care, and reduced reliance on hospital settings will support strategic objectives but is also expected to increase reliance on unpaid Carers to sustain people at home with more complex needs.

While greater integration between health and social care may improve coordination over time, the transition is likely to create additional short- to medium-term pressures. Without commensurate investment in Carer support, respite, and financial recognition, there is a risk of increased Carer strain, widening inequalities, and reduced sustainability of the unpaid care system that underpins service delivery.

What is Impacting Carers?

Own health concerns

Hospital Discharge

Caring from afar

Personal care

Juggling other care commitments

Housing needs

Relationship complexities

Juggling work & caring

Navigating systems

Ever changing systems

Getting a break

No offer of support

Not being able to source care

Access to information at the right time

Self funding care

Finances

Trauma / Guilt

Landscape & Carer Stats : continued

THE PICTURE LOCALLY

52,740 Carers in Worcestershire (2021 census) half are providing 20hrs or more care a week

15,285 Carers registered with the Carers Hub – **29% of Carers identified**

53% of Carers registered are aged over 65

26% will be self-funding care at home

48% of those in care homes will be self-funders

Worcestershire has a higher rate of Carers than the national average (8718 per 100,000 of population compared to 8204 per 100,000 nationally)

THE PICTURE NATIONALLY

Unpaid care is worth an estimated

£184 billion annually

to the UK economy

52% of unpaid Carers say the number of hours they are providing care each week has increased compared with last year.

Nearly **49% of Carers report cutting back on essentials** such as food, heating, clothing, and transport due to the financial pressures of caring.

72% of unpaid Carers have a long-term physical or mental health condition.

51% of unpaid Carers say they need more support from the NHS.

35% reporting “bad” or“very bad” mental health - significantly higher than non-carers

The Programme

An ARF Project Management Group (PMG) was established to provide strategic oversight of the programme. Membership included representation from Adult Social Care Commissioning, the ICB Carer Lead, Taking Care Management, the CEO, DCEO and the Services Manager of C&C, and the ARF Carer Hospital Discharge Development Manager. The group's remit was to ensure delivery remained aligned to the original programme objectives, address emerging risks or barriers, shape implementation in response to system learning, and receive and escalate early findings where appropriate.

Recruitment to the required posts (Hospital Discharge Development Manager and Hospital Discharge Carer Adviser) were achieved within a month, enabling the programme to mobilise quickly. Significant time and resource were invested in the design phase, including mapping relevant system pathways and developing a clear understanding of how Carers experience the hospital and discharge processes. Initial cohort scoping was undertaken in partnership with system stakeholders and progressed more smoothly than anticipated. There was clear interest in the programme, with system leaders recognising its potential to add value and strengthen understanding of Carer experience within discharge pathways.

The Stroke pathway was selected as the initial cohort. This decision built on established relationships within the pathway and provided an opportunity to deepen integration and collaborative working while testing the programme model in a defined clinical area.

Significant time was invested in planning and system set-up to strengthen data capture and ensure a more robust evidence base. This work also focused on bringing the Carer journey to life, enabling a clearer understanding of the Carers experience, needs and outcomes across the system.

The Project Management Group recognised that capturing the Carer journey in real time would generate a significant volume of qualitative insight, offering a depth of understanding not previously available locally. As such, careful consideration was given to defining the key lines of enquiry to ensure data collection was purposeful, proportionate, and aligned to the programme's objectives.

Positioning C&C to lead delivery was a deliberate strategic decision by the local authority. This ensured the programme was grounded in specialist Carer expertise and supported by the knowledge, credibility, and operational experience required to work effectively across hospital and community systems.

Active participation in national learning and improvement activity was central to the success of the ARF Programme, supporting its ability to innovate and adapt over the delivery period.

Engagement with SCIE from the outset helped to shape and strengthen the programme's approach. Early webinars provided a clear conceptual framework, while connections with other ARF areas created opportunities to share insight, test thinking, and build constructive peer relationships such as with Brent ARF Programme. The Worcestershire programme developed a particularly strong link with Gloucestershire County Council, with regular meetings to exchange learning and reflect on progress.

The 1:1 support provided by SCIE was especially valuable, offering constructive challenge, expert guidance, and reassurance as the programme evolved. Participation in SCIE's Communities of Practice further enabled the programme to situate local innovation within the broader national landscape, ensuring alignment with emerging best practice.

The Programme : continued

Additional learning and development activity included training and support through the Research Engagement and Community Health programme in Worcestershire (REACH), which strengthened workforce capability, and the use of the Social Value Engine to support understanding of wider system impact.

Early findings

Early learning from the first few months of the programme identified the following:

- The involvement of a voluntary sector partner with specialist Carer expertise enabled open and constructive dialogue, strengthening trust and relationships across the system.
- System partners demonstrated a clear openness and readiness to improve practice and explore change.
- Fewer structural barriers to innovation were encountered than initially anticipated.
- While strategic drivers to support Carers are in place, there remains a disconnect between policy intention and frontline practice.
- Targeted, small-scale changes within pathways can have a positive impact on Carer experience.
- Capturing and amplifying Carer Voice in real time is critical to understanding system performance and informing improvement.
- Shifting partner priorities within a dynamic system environment can influence programme timelines and delivery pace.

As the programme matured, the Project Management Group considered where the model could add further value, drawing on emerging learning and Carer feedback. Engagement with Worcestershire Acute Hospitals NHS Trust enabled the programme to work alongside the Acute Frailty Ward, based at the Worcestershire Royal Hospital, replicating the stroke model within a different clinical context. This was subsequently extended to the Wyre Forest Ward at Kidderminster Hospital, providing further comparative insight into how Carer experience varied across hospital settings and localities.

Through wider partnership working, the programme also contributed to innovation activity within the Kingfisher Primary Care Network, which was undertaking frailty redesign at a community level. Aligning these complementary strands of innovation strengthened system coherence and ensured that learning from hospital-based work informed community pathway development.

As the programme expanded, careful management of scope and expectations was essential. Priority was given to dedicating sufficient time to each cohort to generate meaningful quality evidence

Further detail on cohort-specific findings can be provided.

Research & Methodology

From the outset, the programme adopted a flexible research approach to understand, in real time, the experiences of unpaid Carers supporting individuals before, during, and after hospital admission and discharge. By “walking the journey” alongside Carers, the programme captured a depth of experience and insight that has not previously been understood in Worcestershire. The primary aim was to understand how Carers are currently supported within hospital settings, where gaps exist, and how these experiences affect both discharge outcomes and Carer wellbeing.

The approach was intentionally designed to generate practice-based learning that could inform service improvement throughout delivery, not only at its conclusion. This enabled emerging insights to shape ongoing practice while building a robust evidence base to support longer-term system change.

At the outset of the ARF programme, the number of Carers who would be supported was unknown, as engagement depended on hospital activity and referral pathways. Over the delivery period, 67 Carers were supported and contributed data. Rather than being defined by predetermined demographic criteria, this cohort was united by shared lived experience and cultural context: **unpaid Carers navigating hospital systems and discharge processes.**

This aligns with the principles of Ethnographic research, in which a cultural group is defined by shared practices, experiences, and interactions within a system. This was selected because it enables a deep dive of lived experience within complex environments such as hospitals; captures how policies and processes are experienced in practice rather than how they are intended to operate; and allows learning to emerge over time, shaped by Carers’ realities.

The research design was deliberately adaptive. Initial research questions focused on baseline Carer experiences of hospital admission, communication, involvement in decision-making, and discharge planning. As learning emerged, the research questions evolved to include the Carers journey prior to admission, explore newly identified barriers and enablers to effective Carer involvement, test service assumptions against lived experience, focus on the Carers own health needs and deepen understanding of specific pressure points within the discharge process.

This approach ensured the research remained responsive, relevant, and grounded in real-time learning, while maintaining analytical rigour through consistent data capture and thematic analysis. Data was collected through ongoing conversations with Carers throughout their involvement with the programme. Methods included structured and semi-structured person-centred conversations; observational insights gathered through direct support within hospital settings; observations shared by ward staff and multidisciplinary teams; and reflective accounts of Carers’ experiences before, during, and after discharge.

This approach enabled the capture of both explicit feedback and contextual insight, including emotional impact, challenges navigating hospital systems, and the informal care roles undertaken by Carers during admission and discharge.

Data was analysed thematically across the full cohort, allowing for identification of recurring patterns and shared experiences, comparison across different hospital touchpoints, and insight into how system processes impact Carers differently depending on timing, communication, and availability of support.

Research & Methodology : continued

The combination of depth at an individual level and breadth across 67 Carers provides a strong qualitative evidence base for understanding systemic issues, while remaining firmly grounded in lived experience. This ethnographic, adaptive approach generated rich qualitative evidence to inform service redesign, highlighted the real-world impact of hospital discharge processes on Carers, and supports system partners to understand not only what is happening, but why.

Ethical practice was embedded throughout the research design and delivery. Recognising the vulnerability of many Carers engaging with hospital systems during periods of stress and uncertainty, the project prioritised approaches that were safe, proportionate, and respectful, while ensuring participation remained meaningful.

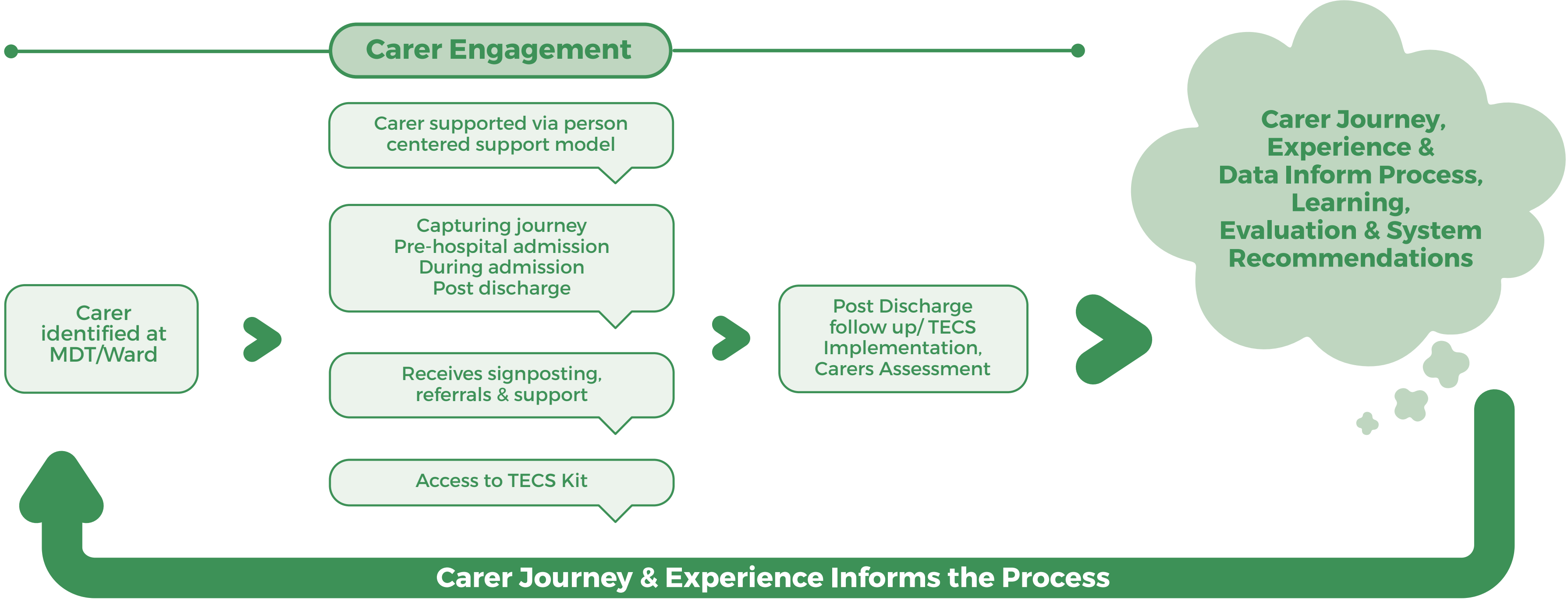
Core ethical principles included safety, competence, transparency, choice, and Carer-led involvement. Engagement took place within existing support relationships, enabling early identification of distress and appropriate signposting where required. Research activities were designed to minimise burden and avoid re-traumatisation, particularly during acute hospital episodes and points of discharge.

All staff involved had appropriate skills, experience, and supervision to work sensitively within complex hospital environments. Carers were recognised as experts by experience, with feedback mechanisms ensuring their voices shaped the evolving research focus. The purpose of the research, use of information, and project boundaries were clearly communicated throughout delivery.

Participation was voluntary, with informed consent treated as an ongoing process. Clear boundaries were maintained regarding the scope of the project and what could realistically be influenced within the funding period, helping to manage expectations and avoid unintended harm or dependency.

By embedding these principles throughout delivery, the research achieved high levels of trust and sustained engagement, generated high-quality qualitative data, and maintained a proportionate approach aligned with public sector ethics and governance standards. This ensured that the learning produced was robust, respectful, and appropriate for informing system-level decision-making.

Research & Methodology



Carer Engagement

Carer identified at MDT/Ward

Carer supported via person centered support model

Capturing journey
Pre-hospital admission
During admission
Post discharge

Receives signposting, referrals & support

Access to TECS Kit

Post Discharge follow up/ TECS Implementation, Carers Assessment

Carer Journey, Experience & Data Inform Process, Learning, Evaluation & System Recommendations

Carer Journey & Experience Informs the Process

Social Impact – Social Value Engine

The ARF Programme utilised the Social Value Engine platform to demonstrate the value of the work undertaken and the outcomes achieved.

The Social Value Engine is the UK's only accredited solution designed to accurately and transparently measure Social Return on Investment (SROI). It provides detailed insight into how SROI calculations are derived, ensuring a robust, evidence-based and auditable approach to valuing social impact.

The tool draws upon more than 500 recognised proxy values sourced from trusted academic and government bodies, enabling consistent and credible valuation of social outcomes.

The platform has been co-produced with East Riding of Yorkshire Council and has undergone ten years of development and refinement prior to national rollout. It is currently used across the NHS, Local Authorities — including Worcestershire County Council — as well as by private sector organisations and VCSE partners.

Benefits of Using the Social Value Engine

- Accurately assesses the impact of services and investment.
- Supports decision-making that balances immediate system pressures with long-term preventative benefit.
- Demonstrates the tangible value of community-based and preventative care.
- Provides clear, transparent and visual representation of social impact and return on investment.

The inclusion of Social Value analysis within the ARF Programme enables the system to articulate not only activity and output, but the broader economic consequences of strengthening — or failing to strengthen — Carer resilience.

By quantifying outcomes such as improved carer wellbeing, reduced anxiety, increased confidence, avoidance of crisis admissions, and sustained caring capacity, the Social Value methodology translates preventative support into measurable economic benefit.

In this context, investment in early identification, advice, education and contingency planning is not solely a wellbeing intervention — it is a discharge sustainability and system resilience intervention.

The Social Value framework therefore provides a structured way to demonstrate that strengthening Carers upstream reduces downstream cost pressures across acute, community and social care services

Technology Enabled Care Solutions

Technology Enabled Care Services (TECS) refers to a range of digital, electronic, and mechanical solutions designed to support individuals to live safely, independently, and with dignity. Within health and social care, TECS includes telecare, remote monitoring, digital prompts, environmental controls, mobility aids, and smart home solutions that help people manage daily activities, health conditions, and risks within their own homes.

TECS is now commonplace across health and social care systems, with its intended use focused on meeting outcomes and mitigating risk for patients and people with identified needs. It is an established enabler of prevention, early intervention, and self-management, supporting safe discharge, admission avoidance, and long-term independence.

The ARF Programme recognises that these outcomes are not achieved in isolation. In many cases, the success of a discharge is dependent not only on the patient being supported, but also on the confidence, capacity, and wellbeing of their Carer.

While TECS has traditionally been deployed to address the needs and risks of the person receiving care, the ARF Programme proposed a broader and more impactful approach: **the initiative-taking provision of TECS to carers to address their own outcomes and needs.**

C&C worked closely in partnership with local experts Taking Care to identify the best solution for quick and simply install of TECS pendant alarms that could be given to Carers prior to discharge and set up easily at home.

By equipping Carers with TECS prior to discharge, the programme aimed to:

- **Reduce risk for both the Carer and the person they support**, through monitoring, alerts, and early intervention.
- **Increase Carer confidence and capability,** particularly following hospital discharge when responsibilities may change or increase.
- **Support Carers to manage anxiety, uncertainty, and care burden,** reducing emotional and physical strain & having regular breaks.
- **Enable shared and supported care,** rather than placing full responsibility on the Carer.
- **Enhancing confidence and capability & reducing Carer breakdown** – especially for Carers new to their role following discharge.
- **Reduce reluctance to discharge,** where anxiety or lack of confidence about coping at home are a barrier to timely discharge.

This approach recognised Carers as key partners in delivery of care and acknowledges that by proactively supporting Carers directly is essential to achieving safe, sustainable outcomes for the person being discharged. Embedding TECS into discharge planning aligns with prevention, home-first, and integrated care principles. It ensures that patients and Carers are supported from day one, rather than relying solely on traditional assessment care models that may be slower to mobilise and less flexible.

Technology Enabled Care Solutions

TECS also has a much boarder role to play than at hospital discharge, with prevention as a core principle of sustainable health and social care. TECS supports **primary, secondary, and tertiary prevention** by identifying risk early, supporting self-management, and reducing escalation.

Providing TECS to Carers contributes to prevention strategies by:

- Preventing falls, medication errors, and unmanaged deterioration.
- Reducing crisis situations that lead to emergency admissions.
- Supporting Carers to manage risks safely and confidently.
- Delaying or preventing escalation to higher-cost care.
- Supporting people to remain independent at home for longer.
- Self-Education – Health monitoring (Fitbit)

From a system perspective, TECS contributes to:

- Reduced length of stay and delayed discharges.
- Fewer unplanned readmissions.
- More sustainable use of domiciliary care.
- Improved carer resilience less Carer breakdown.
- Better value for money and return on investment.
- More efficient discharge planning.

TECS is not a replacement for care, but a critical enabler of modern, efficient, and compassionate health and social care delivery.

By addressing Carer outcomes alongside those of the person they support, TECS strengthens preventative approaches and reduces avoidable demand across the system. This approach shifts TECS from a purely patient focused intervention to a **whole-family and whole-system solution,** ensuring Carers are supported as part of discharge planning rather than as an afterthought.

TECS Data

Where TECS was provided at the point of discharge, the ARF programme indentified the following:

- **18% of Carers chose to have TECS introduced prior to discharge,** indicating a level of acceptance where benefits were clearly understood or perceived.
- **10% of Carers already had TECS in place,** suggesting some existing awareness and use of technology-enabled support.
- **72% of Carers declined TECS at discharge,** indicating that more education and awareness of the benefits of TECS needs to be embedded across the systems.

Carer Profile

The data shows that carers who accepted TECS at discharge were:

- **New to the caring role** 10 of 12 Carers.
- **Female (83%),** reflecting the wider unpaid Carer demographic.
- **Aged 45–95,** indicating relevance across working-age and older Carers.
- **Balancing employment and caring responsibilities,** with 8 Carers in work.
- **Not co-resident,** with 50% not living with the person they care for.

This profile indicates that TECS is particularly valued by Carers who are:

- Newly adjusting to caring responsibilities
- Managing risk remotely
- Balancing care with employment
- Experiencing a sudden increase in responsibility following hospital discharge

Notably, **two working Carers told us that TECS enabled them to remain in employment,** highlighting its role in supporting economic participation and reducing wider societal impact.

Impact & Intensity

The data highlights a significant **increase in caring hours post-discharge** for Carers already providing support prior to admission:

- For those Carers providing 10-20 hrs care per week prior to admission there was a **66.6% increase to 20-30 hrs** and **33.3% increase to 40-50 hrs** of care provided post discharge.
- For those Carers caring for 20-30 hrs per week prior to admission **All** saw a **increase to 30-40 hrs** of care provided post discharge.

Despite this escalation in caring intensity, Carers reported:

- **66% increased** confidence in continuing their caring role.
- **50% improved** ability to manage their own health and wellbeing.
- **A 84% positive** change in how supported they felt compared to pre-admission.

This strongly suggests that **TECS acts as a protective factor**, for Carers, enabling higher levels of care after discharge and advoidence of any crisis escalation.

Confidence and Preparedness Outcomes

Following hospital discharge with TECS in place:

- **66% of Carers reported feeling confident and as prepared as they can be.**
- Compared to just **30% across the remaining Carer cohort.**
- This represents a **36% increase** for Carers reporting higher confidence and preparedness.

Only **9% reported feeling anxious and unprepared,** indicating that while TECS does not remove all anxiety, it significantly improves readiness and resilience.

This finding directly supports the hypothesis that TECS improves discharge readiness and reduces Carer-related risk.

TECS Data

Impact on Carer Health and Wellbeing

Following hospital discharge with TECS in place:

- **58% of Carers reported being fully able to look after their own health and wellbeing.**
- Compared to **45% across the remaining cohort.**
- This represents a **13% increase** attributable to TECS provision.

This is a crucial finding, as Carer health deterioration is a known driver of:

- Unplanned readmissions.
- Care breakdown.
- Escalation to statutory services.

Resistance to TECS

Of those Carers who declined TECS, **6% reported** that TECS was unsuitable due to the person they care for having dementia or were bedbound citing concerns around the practical use of devices, such as pendant alarms.

The primary reason for resistance to TECS was a lack of understanding of the benefits for both the person being discharged and the Carer themselves. Many carers did not perceive an immediate or tangible need for TECS at the point of discharge and therefore felt unable to justify the associated cost.

Qualitative feedback from Carers reflected this perception, with comments including:

- “I feel we are fine without it.”
- “Dementia means we are unable to use a pendant alarm.”

These findings indicate that low uptake is driven less by refusal and more by limited awareness, perceived relevance, and misconceptions about suitability, particularly in relation to dementia. This highlights the need for earlier, clearer, and more Carer-focused conversations about TECS as part of discharge planning.

Insight / Findings

Taken together, the data indicates that TECS:

- Is particularly effective for new Carers, where confidence is lowest.
- Enables Carers to manage increased caring demands.
- Improves confidence, preparedness, and resilience.
- Supports working Carers to remain in work.
- Reduces the likelihood of early Carer breakdown post-discharge.
- TECS benefits are not fully understood or explained to Carers or patients.
- TECS should be embedded as a standard component of discharge pathways to address Carer needs.

TECS Data

TECS Social Return on Investment & Social Impact

Calculations taken from the Social Value Engine Report

Outcome	Outcome Achieved	Impact Value for Yr1
Cared-for individuals are able to remain independent for longer, reducing the need for more intensive care or residential placements.	12	£149,688.00
Carers experience reduced financial strain due to better access to support, advice, or flexible work arrangements, making their caring role more sustainable.	8	£34,035.72
Carers experience less stress and improved wellbeing, making their caring roles more sustainable over time.	8	£4,469.76
Falls prevention	12	£4,826.88
Carers experience better physical health as a result of support, training, or respite, enabling them to sustain their caring roles longer and more effectively.	7	£91,731.53
Carers are less socially isolated due to support, networks, or respite, helping them sustain their role.	12	£21,174.05
	Total Impact Value	**£305,925.94**
	Total Input	**£3,684.00**
	Social Return	**£80.23**

TECS Data

TECS should be viewed not solely as a tool for individuals with care needs, but as a system-wide intervention that strengthens Carer outcomes, improves discharge flow, and delivers better outcomes across health and social care.

The ARF Programme TEC Recommendations

Recommendations

Adopt a partnership-led, system wide approach to developing consistent messaging, communications, and information/education materials that clearly articulate the benefits of TECS for both Carers and the people they support.

TECS should be positioned as a core component of discharge planning, rather than an optional or late-stage intervention. Ensure TECS is routinely available to Carers prior or very close to hospital discharge, with practical training and guidance provided to support effective use.

Evidence from the programme demonstrates that new Carers benefit most significantly from TECS, particularly in terms of confidence, preparedness, and wellbeing. Embed early and systematic identification of brand-new Carers within discharge pathways, ensuring they are proactively offered TECS and carer-specific support before discharge.

Achieving the Recommendations

Collaboration between: Health Services, Adult Social Care, Taking Care, VCSE, delevoping materials on how TECS supports Carer confidence and wellbeing, mitigates risk and supports safer discharge, provides Carer breaks.

Clear explanation of how TECS can be used to mitigate risk, and supports safe discharge, time for Carers to ask questions and build confidence before discharge.

Early Carer identification during hospital admission, Clear referral routes to TECS and carer support services, Recognition of sudden increases in caring responsibility post-discharge.

> **“The ARF Programme has shown unequivocally, that Carers are the golden thread running through safe discharge and sustainable care at home. When we give Carers the right support at the right time (including Technology Enabled Care) we don’t just improve confidence, we improve outcomes for the whole system. If we want safer, faster, and more sustainable discharges, we must support Carers and TECS is one of the simplest, most effective ways of doing exactly that.** **MITCH HYDE - TAKING CARE**

What we learnt from the Carer Journey

- 67 Carers supported across cohort.
- 31% of Carers are new to caring and no previous caring role.
- 24% of the cohort's patients had previously had a hospital admission, only 44% of those Carers felt they were involved in the previous discharge planning and only 8% Carers advised they were provided with support for themselves at that time.
- 34% of the cohort said that the patients were currently being supported by their GP or neighbourhood team, however no Carers said they had been registered on EMIS* as a Carer.
- 33% of cohort was known to social care and receiving support.
- Only 1 Carer had been referred by social care for a Carers Assessment.
- 15% of Carers said that the patient had a Package of Care – 55% were self funding and 45% funded via social care.
- Only 3% of Carers has regular social care funded replacement care.
- Only 6% of the cohort were previously refered and supported by the Carers Hub, delivered by Carers and Communities.
- 45% of Carers said they felt they were not included in planning for discharge conversations.
- 73% of Carers said that their own needs/concerns were not considered by staff when planning for discharge.

Carers Reporting to be able to look after their own health & wellbeing alongside their caring role	Prior to Admission	After Discharge
No - Not at all	11%	24%
Yes - But my health needs are secondary	49%	33%
Yes - I am fully able to look after my health needs	40%	43%

Carers reporting how their caring role feels for them	Prior to Admission	After Discharge
I feel I have no control over the situation	38%	30%
I feel anxious and unprepared	6%	26%
With support I feel everything will be ok	22%	12%
I feel as confident and prepared as I can be	34%	32%

*Emis is an electronic patient record system used within all Primary Care settings in Worcestershire. Patient Records can have a marker placed on them to indentify if that patient is a Carer.

What we learnt from the Carer Journey : continued

Carers reporting if they understood the level of care they will need to provide after discharge	Prior to Admission
No	20%
Unsure at this time	50%
Yes	30%

Carers reporting if their own needs were considered by staff around planning for the discharge?	Prior to Admission
No	73%
Yes	27%

Carers reporting number of hours caring per week	Prior to Admission	After Discharge
Less than 5 hrs	12.50%	10%
5-10 hrs	35%	15%
10-20 hrs	22.50%	20%
20-30 hrs	7.50%	12.50%
30-40 hrs	15%	25%
40-50 hrs	5%	7.50%
50+ hrs	2.50%	10%

Learning from observations

Multidisciplinary Meetings

During multidisciplinary team (MDT) meetings, insufficient social care input presented challenges in identifying timely solutions and, in some cases, this contributed to delayed discharges. Complex discussions regarding social care processes, particularly for self-funders, were often left to clinical staff who reported uncertainty and a lack of confidence in navigating social care pathways. This highlights the need for strengthened system-wide collaboration and a consistent, embedded social work presence within hospital discharge planning processes.

Recognition of Carers, and the systematic inclusion of their voice within MDT discharge planning, is critical to achieving safe, effective, and sustainable discharges. Carers were frequently absent from discussions, and where referenced, their capacity, willingness to provide care, and the impact of caring responsibilities on their own health and wellbeing were not consistently explored. Failure to identify and involve Carers at an early stage created avoidable barriers later in the discharge pathway, resulting in delays, increased risk, and discharge arrangements that did not fully reflect the realities of care provision at home.

Acknowledgement of Carers often occurred too late—at the point of discharge planning—when risks and barriers were already complex and difficult to resolve within required timeframes. This reactive approach contributed to strained communication, heightened Carer stress and anxiety, reluctance to accept discharge arrangements, and perceptions of Carers was that decisions were rushed and insufficiently planned. Observations also indicated that staff were not always equipped with the skills, confidence, or protected time to engage in complex, emotionally sensitive conversations with Carers, many of whom presented as traumatised or highly distressed. Carer feedback suggested that difficult discussions were sometimes avoided, potentially reflecting workforce pressures, limited training in trauma-informed and carer-focused communication, or uncertainty regarding roles and responsibilities.

The absence of structured, confident engagement with Carers increases the risk of misunderstanding, conflict, Carer breakdown, avoidable readmissions, and escalation back into acute services. Embedding earlier Carer identification, proactive assessment, strengthened social care integration, and targeted workforce development is therefore essential to mitigate risk and support coordinated, sustainable discharge outcomes.

Additionally, the integration of voluntary, community, and social enterprise (VCSE) organisations within MDT's provides significant added value to discharge planning processes. VCSE partners bring an in-depth knowledge of local communities, condition-specific services, and practical resources that may not be known within health and social care systems. Their insight can support more personalised, preventative, and strengths-based discharge planning.

VCSE organisations are often well placed to identify early risks related to social isolation, financial hardship, housing instability, Carer strain, or mental wellbeing, and can mobilise flexible, community-based solutions at pace. This can include peer support, practical assistance, carer support services, transport solutions, and low-level preventative interventions that reduce the likelihood of crisis or readmission. Where VCSE representation is absent from MDT discussions, opportunities for creative, community-led solutions may be missed, resulting in an over-reliance on statutory provision or delays while formal services are arranged. Embedding VCSE partners within discharge pathways strengthens system resilience, enhances holistic assessment, and supports smoother transitions from hospital to home by bridging the gap between hospital care and community-based support.

Formalising VCSE involvement within MDT structures—through clear referral pathways and defined roles, would support more integrated, person-centred discharge planning and contribute to improved patient and Carer outcomes while alleviating pressure on acute and statutory services.

Visiting Policies

During time spent on the wards, it was observed that Carers often have unrestricted access to visit patients, whist the John's Campaign and the willingness of wards to be flexible around visiting is largely positive for some, it can result in over-caring. While Carer involvement is well-intentioned, this lack of boundaries can prevent Carers from taking necessary breaks and attending to their own health needs resulting in burn out before the discharge has happened. Additionally, it was observed that the constant presence of visitors can be disruptive to other patients and places extra pressure on staff, who must balance supporting Carers with providing appropriate care for all patients. This highlights a need for clear ward policies that promote Carer involvement while ensuring the wellbeing of both Carers and the wider patient population.

Barriers to Discharge

A consistent and unhelpful theme emerging from this work is the perception that Carers can be viewed as a barrier to hospital discharge. In pressured hospital environments, it can be easy to attribute delays to perceived reluctance from families. However, the evidence gathered through this programme highlights that the reality is significantly more complex.

Situations that may appear as unwillingness to resume or take on caring responsibilities often reflect deeper and multifaceted factors, including:

- Trauma or strained historical relationships.
- The Carer's own physical or mental health limitations.
- Pre-existing Carer strain or breakdown prior to admission.
- Lack of clear information about what caring will involve post-discharge.
- Financial pressures and challenging living circumstances.
- Inequality experienced by self-funding families.
- Limited access to timely advice, education or respite.
- Assumptions made in the absence of structured conversations.
- The legal right of Carers to decline or limit their caring role – make no assumptions that Carers are willing and able to provide care.

Without early identification, meaningful involvement in discharge planning, and realistic conversations about capacity and expectations, Carers may feel overwhelmed, excluded or unprepared. This can present as hesitation or resistance, when in reality it reflects risk, uncertainty and insufficient support.

As system priorities are driving towards Hospital at Home and with mounting pressures on patient flow and availability of beds, it is essential to recognise that accelerated discharge models will require equally strengthened Carer engagement and appropriate levels of support and resilience planning. Without this, there is a risk of increasing reluctance, delayed discharges, avoidable readmissions, and heightened pressure on social care resulting from Carer breakdown. Addressing this issue requires leadership across the system to move beyond surface narratives and engage with the underlying issues to ensure caring capacity. Sustainable discharge is not solely a clinical decision; it depends on honest dialogue, shared understanding and proactive support for those expected to carry care forward at home.

Carer Education

Education emerged as a key theme from conversations with Carers, who expressed a strong desire to understand more about the illness or disability of the person they care for, including how it occurred, how to prevent it from happening again, and what warning signs to look out for. Receiving this knowledge helped Carers feel prepared and feel confident, enabling them to ask more informed questions of staff and participate actively in care decisions.

Providing structured education programmes on hospital sites, such as the Family Education Group on the Evesham Stroke Wards, as well as opportunities for Carers to participate in physiotherapy sessions, has demonstrated significant benefits for Carers.

Feedback from all Carers who attended these programmes was consistently positive, highlighting:

- Increased preparedness.
- Greater involvement in the patient's care while in hospital.
- Enhanced ability to reinforce recovery and rehabilitation messages in the home environment.

The Programme identified a need for more targeted information and education, particularly regarding the Frailty pathways. Carers were provided with information and guidance on key areas, including falls prevention, hydration, moving and handling, hospital-acquired decline, dementia, delirium, and condition-specific care by the Carer Adviser. However this would be a useful tool kit for all Carers caring for someone living with frailty especially before a hospital admission has happened to reduce the chances of the need for an admission.

This approach equipped Carers with practical skills and knowledge necessary to support patients effectively at home. The combination of structured education and hands-on training not only enhanced Carers' confidence, but also contributed to:

- Improved patient outcomes.
- Reduced risk of complications.
- Timely hospital discharges.
- Lower likelihood of readmission.

By empowering Carers in this way, the programme strengthens the continuity of care between hospital and home, benefiting both patients and the wider health and social care system.

The Herefordshire & Worcestershire Health & Care NHS Trust has developed the Prepare to Care checklist, a tool designed to support Carers in preparing for their caring role following a patient's hospital discharge. The checklist prompts Carers to reflect on the practical and emotional aspects of caring, and encourages them to consider important questions to ask ward staff.

Learning from observations : continued

Despite its clear potential, the Prepare to Care checklist is currently largely unused. The Programme found that none of the Carers within the Trust's cohorts had been offered the document at any point during the hospital journey. This highlights a significant gap: practical, evidence-based tools that could empower Carers are not being routinely provided, revealing a disconnect between policy intentions and actual practice on the wards.

The programme conducted a small-scale test of the checklist with two Carers. Feedback was overwhelmingly positive:

- Both Carers reported feeling empowered to initiate conversations with ward staff and ask questions they had not previously considered.
- They appreciated the opportunity to reflect on the impact of the caring role on their own wellbeing.
- They expressed confidence in understanding the support they would need to successfully transition to caring for their loved one at home.

This represents an example of good practice that should be adopted Trust-wide. It is recommended that the Prepare to Care checklist be provided to every Carer at the point of patient admission, ensuring Carers are supported from the very start of the hospital journey. Implementing this consistently across all Worcestershire Trust sites would improve Carer preparedness, confidence, and ultimately patient outcomes.

These initiatives empower Carers, strengthen the continuity of care, and contribute to improved patient outcomes.

Working Across Pathways & Sharing Innovation

The Programme was able to enhance the work and understanding by joining the Kingfisher PCN in Redditch around the innovation work with their Frailty patients.

Local and national data indicate a growing need to support frailty admissions and discharges. This underscores the importance of a planned, proactive approach that incorporates robust carer support throughout the patient journey.

The insights from this work provided clear evidence of the need to integrate frailty pathways across acute, community, and PCNs, that proactively identify frailty patients and their carers. There is clear direction and drive to adopt this proactive model to frailty. This joined-up multidisciplinary approach ensures that Carers are supported consistently throughout the entire patient journey, enhancing both patient outcomes and carer preparedness.

Carer Identification and Pathway Development

Carers participating in the Programme reported that they had not been identified or acknowledged as Carers during the hospital journey. Data from the cohort confirms this: only 33% Carers were already known to Social Care and only 6% known to Carers and Communities prior to the hospital admission, highlighting that Carer identification levels are below expected figures and that Carers are not receiving vital support when they need it.

Learning from observations : continued

This is not a new learning, in response to this the Herefordshire & Worcestershire Health & Care Trust has been working to implement a trust-wide solution for Carer identification. The new RIO* system now includes a Carer Identification tab on the patient record, which:

- Records who the Carer is and captures essential information for staff.
- Can be updated over time to build a comprehensive understanding of the Carer's needs.
- Embeds referral forms linking directly to relevant Carer support organisations across Herefordshire and Worcestershire.

Working with the Programme, the Trust recognised that identification alone is not enough; what matters is the "so what"— how identification translates into support and action. The RIO Carer Identification tab now enables:

- Monitoring and evaluation of the role out of the initiative.
- Targeted staff training.
- Tracking of Carers identified and referred for support.

This represents a significant innovation and the first step toward an embedded Carer Pathway, which over time will provide valuable data to demonstrate impact. The Programme recommends this as good practice and encourages its further development across the wider health and social care system.

Carer Health Inequalities

The Programme has highlighted the significant impact that caring has on Carers' own health, which is increasingly evident in two key ways:

1. Carers managing their own complex health conditions while providing care for others.
2. Carers whose health deteriorates due to the burden of the caring role.

Factors such as high levels of responsibility, limited time, concerns for the future, not accessing regular breaks and pressures from health and social care systems all contribute to this impact. While health issues vary, the Programme has observed a notable rise in mental health challenges among Carers. The Programme found that, in many cases, unwell people are caring for other unwell people, and Carers are not recognised as patients in their own right. Health professionals are often not taking proactive steps to prevent ill health among Carers, leaving them at risk of deterioration and crisis.

The nature of caring often means the Carer's needs are deprioritised, with little recognition of the burden they bear. Across the cohort:

- Carers' health and wellbeing were rarely assessed proactively.
- Identification often occurred only to gather information about the patient, rather than to understand the Carer's own health or capacity.
- In some cases, post-discharge crises occurred when Carers' health deteriorated to a point that it could no longer be ignored.

The Programme recognises that Carer health inequities are a growing and urgent issue. Addressing these inequalities is essential to ensure that Carers are supported, safe, and able to sustain their caring role, ultimately improving outcomes for both Carers and the patients they care for.

*Patient record system

Carer Digital Offer

The forth area of focus for the ARF Programme was to identify and secure a digital resource that enable Carers to access accurate information, advice, and support in a timely and accessible way. It was recognised from the outset that leading platforms in this space increasingly incorporate elements of artificial intelligence (AI) to enhance usability, responsiveness, and personalisation.

The Programme has conducted research, reviewed multiple platforms, and undertaken testing to determine the most appropriate solution for Carers. This work remains ongoing to ensure that any selected platform meet the following requirements:

- Meets robust governance and data security standards.
- Provides reliable and accurate information.
- Is accessible and user-friendly for Carers with varying levels of digital confidence.
- Has the capability to scale and evolve over time in line with system and Carer needs.

The Programme has been clear that innovation must be purposeful. Pursuing digital solutions for innovation's sake would risk compromise. Instead, the focus remains on securing a platform that is practical, sustainable, and demonstrably beneficial for Carers, with the flexibility to expand and integrate across systems where appropriate.

System Outcomes of the Programme

The ARF programme has delivered meaningful system impact beyond individual Carer engagement. Key contributions include:

Impact Area	Evidence from ARF Programme	System Benefit
Partnership Strengthening	Sustained collaboration across health, social care and VCSE partners throughout programme delivery.	Improved system cohesion, shared ownership of discharge sustainability and stronger integrated working.
Innovation & Co-Production	Locally designed model tailored to Worcestershire context rather than replication of a national template.	Increased relevance, adaptability and alignment with local pathway pressures and discharge realities.
Carer Voice Embedded	Lived experience captured in real time and fed into operational and strategic discussions.	Pathway redesign informed by frontline impact, improving discharge safety and sustainability.
Qualitive Evidence Base	Full datasets and consistent thematic insight across wider cohort.	Credible system intelligence demonstrating the direct link between discharge processes and Carer resilience.
Health Inequalities Awareness	Identification of Carer strain, isolation, and economic impact across varying demographics.	More equitable consideration of Carers within pathway planning and commissioning decisions.
VCSE Recognition	Clear demonstration of VCSE expertise in engagement, prevention and early intervention.	Stronger case for embedding VCSE partners formally within discharge pathways and transformation programmes.
Early Carer Identification	Engagement of 67 Carers during acute admission.	Improved understanding of how early identification reduces crisis escalation and supports discharge readiness.
National Recognition	Recognition from the Social Care Institute for Excellence (SCIE) for the Worcestershire ARF approach.	External validation of model credibility and alignment with national improvement priorities.
Proof of Concept Real Time Engagement Model	Live testing of system interaction during admission and discharge phases.	Scalable model for future transformation, enabling rapid feedback, performance insight and pathway redesign.

Recommendations & Conclusion

The Accelerating Reform Fund has provided a unique opportunity for Worcestershire to test and scale innovative approaches that empower Carers at hospital discharge. Through strong partnership working and a commitment to shared learning and innovation, the programme has created a foundation for lasting improvement in how Carer support is delivered, experienced and sustained locally.

However, the value of this learning will only be fully realised if it is translated into action. The programme has demonstrated that improving outcomes for Carers, patients and the wider system require strategic leadership, sustained collaboration, and a willingness to embed new ways of working into everyday practice.

While recognising the pressures facing health and social care, the findings from this programme provide clear direction on where commitment to change is needed. The recommendations that follow set out practical, system-focused actions to strengthen Carer identification, improve discharge processes, provide levels of accountability and support more sustainable service delivery across Worcestershire.

Recommendations & Conclusion : continued

Findings

Carer Identification : Remains inconsistent and significantly below expected levels. Where identification does occur, it is primarily in response to patient need rather than through a proactive, systematic assessment of Carers' own needs and wellbeing.

Involvement in Discharge Planning and Support : Carers report limited involvement in hospital discharge processes and insufficient consultation regarding ongoing care arrangements. Many Carers express reduced confidence in their ability to manage post-discharge and highlight that their own support needs are not being routinely assessed or addressed.

Policy into Practice : Although relevant policies are in place, implementation at an operational level is within hospitals poor. This indicates a gap between strategic intent and frontline delivery, resulting in inconsistent experiences for Carers. (NHS Trusts Carer & Discharge Policies)

System Integration and Statutory Duties : At a strategic level, partnership working across health and social care is not yet sufficiently aligned to ensure full compliance with statutory duties toward Carers. Greater system integration is required to deliver a coherent, legally compliant approach to identifying, supporting, and empowering Carers.
(Health & Care Act 2022 & Care Act 2014)

Policy & Partnership Focused : There remains a need to strengthen policy delivery on the ground of system-wide recognition of Carers as partners in care, ensuring they are actively involved, valued, and supported across health and social care pathways. (ICB Commitment to Carers)

Role of Technology Enabled Care (TEC) : Evidence indicates that access to Technology Enabled Care (TEC) tailored to Carers' needs improves confidence in managing caring responsibilities. TEC also supports Carers to maintain their caring role while balancing their own health, wellbeing, and independence.

Recommendations

System-wide approach to Carer identification : System-wide approach to Carer identification, develop a standardised Carer Pathway to support ensuring consistency across all services, and focused on recognising Carers, not solely in response to patient needs.

Dedicated Carer Service aligned to discharge pathways : Establish a dedicated Carer Service to proactively identify, engage, and support Carers throughout the hospital discharge process, ensuring Carers' needs are assessed and addressed as part of routine care planning.

System-wide performance framework and dashboard Data Insights for Sucessful Carer Outcomes (DISCO) : To support staff to better understand the requirements in relation to Carers and to establish a system-wide Carer Dashboard to provide performance oversight, monitor health inequalities for Carers, and support quality improvement, and countywide consistency in delivery of successful Carer outcomes.

Carers Strategy aligned across partners : Develop a single, integrated Carers Strategy that aligns ICB and Local Authority policy objectives and embeds a shared vision across the system, using the 'Carers as the Golden Thread' principle as the unifying framework.

Executive-level endorsement and leadership : Secure formal ICB & Local Authority endorsement of the 'Carers are the Golden Thread' principle, supported by senior leadership to strengthen accountability, governance, and system-wide implementation.

Technology Enabled Care (TEC) at hospital discharge : Implement Technology Enabled Care (TEC) solutions at the point of hospital discharge to improve Carers' confidence, resilience, and ability to sustain caring roles alongside their own health and wellbeing.

> **Innovation is the ability to see change as an opportunity - not a threat.**
>
> **STEVE JOBS**

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Accelerating Reform Fund

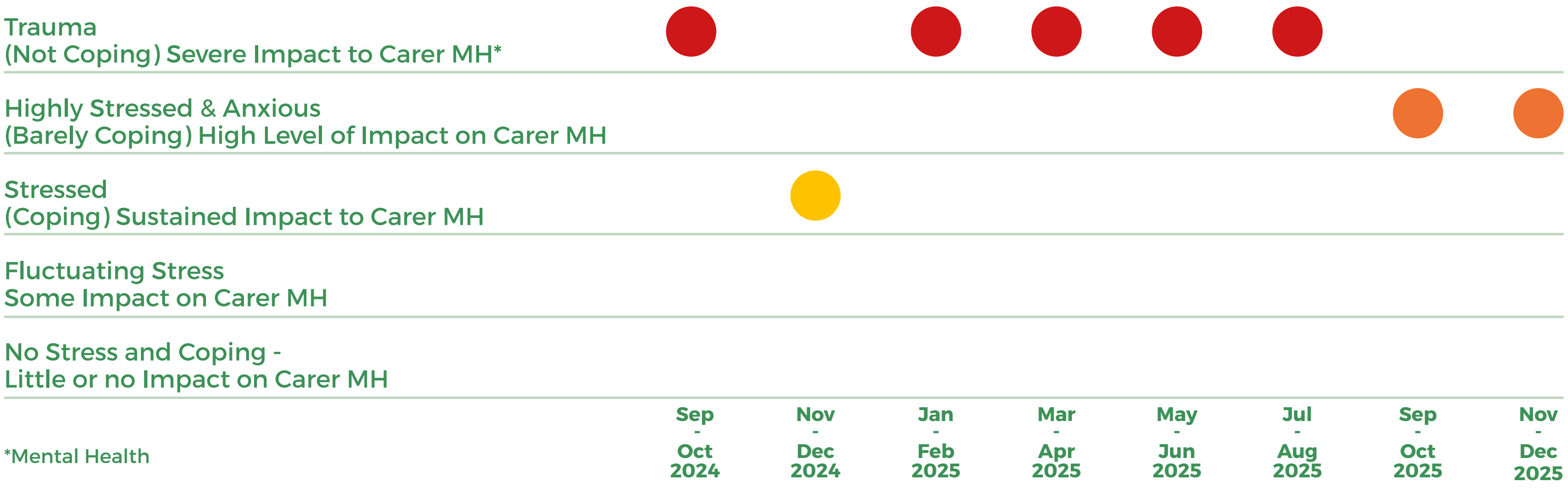
Carer Stories

Carers are the golden thread

These Carer Stories illustrate how system gaps impact Carers. They demonstrate how avoidable situations that accumulate across pathways and over time, and can adversely change outcomes for patients and Carers. The following experiences are representative of themes seen throughout the ARF programme.

Carer Story A

Stroke Carer Case Study A - Heat Map



Background

Carer:
Female, Aged 65, White European, reported illnesses of depression & hernia, working part-time (18 hrs)

Relationship to Cared For:
Wife

Other Family & Support:
One daughter & two grandchildren

Cared For:
Male, Aged 72, White British, previous open-heart surgery, retired, no previous care needs

Prior to stroke:
Both active and relocating to Worcestershire to be closer to daughter & grandchildren

Carer Story A

Sep 2024

Stroke happened during their house move and her husband was admitted to an acute hospital in the south of England. This was incredibly traumatic for the Carer as she was present at the time, it was scary and unknown and she was frightened for herself and her husband.

Nov-Dec 2024

During the time following the stroke it continued to be stressful for the Carer as she began to understand how life changing this was for both herself and her husband. She had to leave him in hospital and continue to move house on her own, being unable to visit as much as she would have wanted was difficult, adding to her stress and feelings of guilt. She began to feel that she was tiring and was scared she would burn out. Whilst care for her husband was good there was no support for her, but she felt that the situation would settle down and felt optimistic about him moving to a hospital near to where they now lived in Worcestershire.

Jan 2025

Husband was transferred to Evesham Community Hospital; this was traumatic again for the Carer as she had not been prepared and not been given any information or details around what to expect. Her husband arrived at Evesham hospital and not one member of staff spoke to her or provided any information, it was very scary and did not feel that her feelings were taken into consideration. Her impression was that she was not identified as her husband's Carer.

Carer Story A

Feb 2025

In February, the Carer met with the Carer Support Advisor (CSA) from the ARF Programme on the ward following an MDT where the advisor asked for a referral to support the Carer.

The Carer was visiting her husband every day and advised that she felt very unsure of what the caring role would look like following discharge and that she felt totally unprepared, however she felt that with support everything would work out and felt determined to bring her husband home as independent as possible. She said she felt like **“bringing a new baby home”**. She had lots of anxiety about the new house and if it would now be appropriate for her husband’s needs. She also shared concerns around finances, and she felt that the only way they would be able to cope with caring for him would be to reduce her hours or stopped working, which financially she did not think they could afford. She shared that due to the stress, anxiety and lack of sleep, she knew her own health and mental wellbeing was declining. With encouragement from the CSA, she went to see her GP. She said that she was really struggling to look after her own mental health and did not feel she would be able to at all after discharge and was very worried about burn out.

No one from the wards at the hospital had spoken with her regarding discharge planning and what to expect but said that an Occupational Therapist (OT) would be coming to the house to do an assessment. She had not had any information or support regarding her husband’s therapy and what that would look like other than them asking her what her husbands’ baseline had been prior to the stroke. She had continued stress around how she would manage and how she would balance work with her caring role, spending time with her family as well as having a break and looking after herself.

> **“There isn’t enough communication from staff, when I ask, I’m told is that my husband is progressing well.**

The Carer said that she didn’t feel she was able to ask questions about the discharge or what the caring role would look like once her husband was home because she didn’t feel seen or listened to, and said it felt like she was not involved at all and no longer felt reassured or confident for what the discharge would bring.

> **“I haven’t had a conversation with anyone around my husband’s condition, I am obviously aware that he has had a stroke but future expectations & progress have not been discussed with me, I am just told he is doing ok.**

The CSA offered emotional support and information about what the caring role might look like, information on how to look after her own wellbeing and encouraged her to request to attend therapy sessions with her husband so she could better understand this. Unfortunately, she was unable to attend the family education sessions due to work commitments and not being able to change her hours of work, she acknowledged these would have been helpful to her.

Carer Story A

Mar-Apr 2025

The Carer was able to attend a therapy session to observe and felt more prepared about what to expect around the levels of support her husband would need, understanding this did leave the Carer with a lot of anxiety and was now unsure as to how she would cope. She could also see that her husband was struggling to come to terms with what life would be like and she had concerns about how she would manage her husband's emotional needs and support with motivation. The Carer began to think that she would need to reduce or give up work completely.

The CSA advised of some helpful solutions one of them being Technology Enabled Care (TEC) which was something that the Carer could really see helping her maintain going to work and getting a break, she wanted to have some level of routine and work that would allow her to focus on things for herself and help with peace of mind around leaving her husband at home and reduce her feelings of guilt.

The Carer said that her husband would be discharged on Pathway 1 and she had not been involved at all in the discussions around discharge planning, her own needs had not been considered and she didn't feel that she was a partner in her husband's care. No choices had been explained to her. When the discharge did happen it felt very rushed to them both, the care package provided felt very last minute which led to high anxiety levels for her. It felt like everything was being done to them and around them. The Carer said **"they may do this every day but for us this is the first time and its very scary".**

> “My own needs were not considered upon discharge.

The Carer when asked by the CSA said that what would have been most helpful at the time of discharge was being **"more involvement and help from the staff managing my expectations of the level of care I was being expected to provide & what support would be available once home, also expectations on what would happen on the day of discharge, there were huge delays with hospital transport which made a difficult day even more stressful for both of us".**

The Carer said that neither her or her husband were given enough information around strokes, the new medication, moving and handing safely or what support would be available to them once home. The Carer realised that this was going to be more difficult than she had first thought and it filled her with dread. When asked, the Carer had not been given the Trust's **Prepare to Care Checklist** which when she looked at it, said it would have been useful earlier on to help her think through some of the implications of what life would look like for herself and her husband.

> “I feel very much left on my own by the staff and need to navigate this on my own.

The Carer advised that once her husband was home following a transport delay, she said the first few days were very unnerving and incredibly stressful and she could not sleep or have a break. She was provided with useful numbers one week after the discharge and had no idea when the physio team would be coming out. Both the Carer and her husband felt genuinely concerned about this and worried he would decline after intense therapy at the hospital. The husband's mental health was declining and because of this the Carer's was too.

Carer Story A

The Carer advised that initially they had one care call in the morning to help her husband up and out of bed, get washed and dressed and down the stairs; this was reassuring for them both. However on day 3 the paid in Carers were later arriving so the Carer had to support her husband to get up and washed and down the stairs, this was very dangerous for them both and took a long time, as the Carer had not been shown how to do this safely and they knew it was a risk but felt it was their only choice.

When the Carers arrived they told the Carer that as she had managed to assist her husband down the stairs on her own then they would not need to visit again. When the Carer advised them that it had been unsafe and she was very nervous doing it and didn't feel it was safe or either of them, she was told that they would not be coming back. She asked if they could show her how to do this more safely and again, she was told no and they left. With no further explanation or where support might be coming from next the Carer felt she had been completely abandoned and she was angry and stress levels were high again. The Carer advised that what did go well at this time was that the equipment was delivered very quickly and once they knew about the Neighbourhood Team, they were excellent. The Carer also said that the only thing that really gave her reassurance and peace of mind was having had the TECS in place on the day of discharge and she felt reassured that it was in place and that it would eventually allow her a break and continue to work.

> ❝ We both feel that having the TECS is a case of prevention better than cure.

The CSA had provided them with a wrist pendant, and it is worn every day, it gives them both confidence that help will be there if they need it. The paperwork was completed with the CSA prior to discharge in the hospital and was in place the morning of the discharge which was the only practical thing on that day they gave her confidence.

Three weeks post discharge the Carer was now reporting that she was caring for 30-40 hours per week and barely managing, there was no support from the community stroke team or The Stroke Association and they had heard nothing about when physio's would be coming in. The CSA chased the community stroke team to find out when the physio would be in place but was not given a time frame. In the meantime, the CSA gave the Carer a link to an online video from Different Strokes that gave some exercises the Carer could be doing with her husband as his mobility had significantly declined after 3 weeks at home without therapy input. This gave them some confidence and they did this every day. The Carer supported her husband with motivation as this had dropped due to feeling abandoned and his mental health was still declining.

> ❝ I still feel very frightened and unsure what the future will look like, I have a real fear of leaving him due to falls, the TECS is helping with this, but I feel really guilty, leaving him is a huge decision. We desperately want him to get stronger so he can just get in the car for a drive, but it feels like an up high fight.

The Carer felt that much quicker input was needed following the discharge to continue with the improvements made after the intense therapy in hospital to give them both the best chance.

Carer Story A

May-Jun 2025

During follow up with the Carer she said she felt exhausted and constantly on high alert, she wanted things to improve but everything was really time consuming and difficult. She could not get a break, and she had made the decision to give up work. Work was a lifeline for her in getting a break, maintaining social support and for financial reasons.

> I can't see how I will be able to work again.

The Carer said she can see her daughter and grandchildren, but they must come to her, and they are not able to go and do nice things like they did before.

The Carer advised that the support from the CSA whilst at hospital and post discharge has been invaluable, someone to talk to who understands what she was going through had been a lifeline for her, giving her lots of practical support and information that without it she would have felt lost. From what she could see no one else was going to provide anything to her.

She had been provided with a Carers Emergency Card, information on how to get a break, encouragement and support around prioritising her own health concerns, a Carers Assessment, training on Moving and Handling, a Data Link Pot, assistive technology and referrals to the Fire Service, DWP for applying for benefits, Headway, Stroke Association and chasing the physio input.

The referral to the Stroke Association has meant they have joined a fortnightly online group with other Carers and Stroke survivors and have been able to access physio sessions at the college with student physios for which they pay a nominal amount, this has been beneficial to them both. The Carer is starting to feel less anxious and stressed and they can both see that things are starting to settle for them.

Carer Story A

Jul-Sep 2025

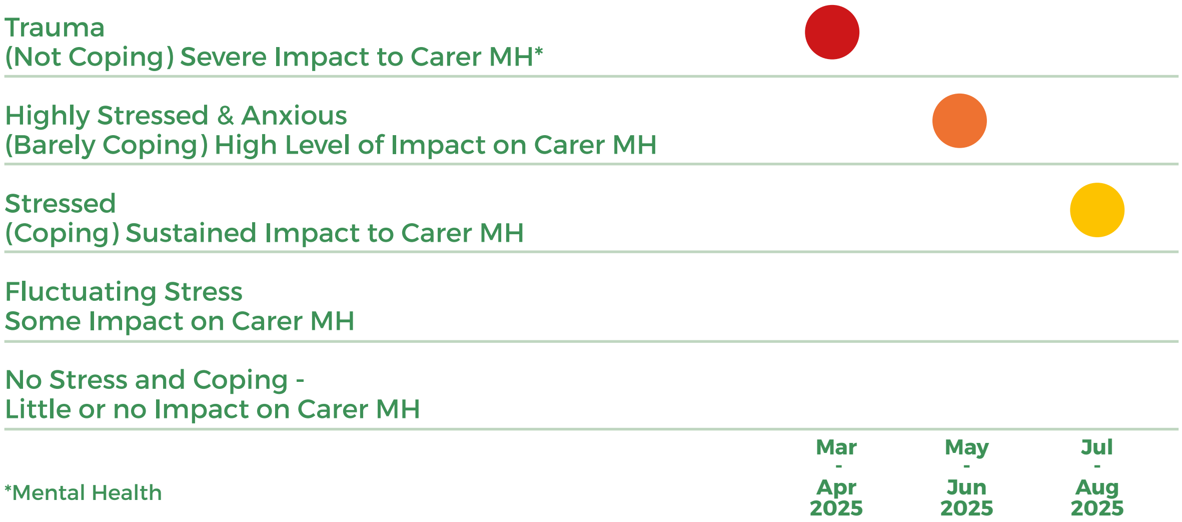
Follow a check in call with the Carer, she advised that, on taking advise from the CSA she went back to GP regarding her own health and was diagnosed with a life changing illness that leaves them both very scared for the future. She was starting treatment quickly and the CSA supported with how they could manage both her and her husband's needs. It would now be vital to ensure she has breaks to address and look after her own health needs. Following a successful trial day at Headway as suggested by the CSA, her husband wanted to attend the sessions several times a week to allow a break for the Carer to have treatment and recover. The CSA made a referral to Adult Social Care for an urgent needs assessment and consulted with a Social Worker to ensure an assessment and a package of care, including transport was in place as soon as possible. The Carer also had a Carers Assessment and is being supported with benefits in her own right.

> “ Not being able to focus on my own health has had a terrible impact on mine and my family's lives.

This had been a traumatic time for the Carer and her husband and will continue to be challenging and require support for them both. The Carer felt that not being able to focus on her own health and dealing with high levels of trauma and stress has significantly impacted her own mental health and delays in seeking support around her own physical health due to the constant pressures of the caring role has had a detrimental impact.

Carer Story B

Stroke Carer Case Study B - Heat Map



*Mental Health

Background

Carer:
Male, Aged 73, White British, Retired, No ill health, no previous caring role

Relationship to Cared For:
Husband

Other Family & Support:
Son who does not live close by

Cared For:
Female, Aged 75, White British, No previous ill health

Carer Story B

The Carer wanted to share his and his wife's experience of his wife having a Stroke and being admitted to the Acute Hospital - the following are details that he wished to share in his own words, he feel's their experience could add valuable insight and learning to the ARF Programme and give better understanding into the levels of trauma that Carers face that is not taken into account when identifying and supporting Carers.

Mar 2025

"On 5th March my wife was rushed by ambulance to Worcestershire Royal Hospital, we then waited 12 hours in a corridor in A&E with all indications my wife having suffered a stroke. Initially I was relieved that we were at the hospital, but my ANXIETY grew greatly as no action or treatment was given. My wife needed the toilet, and no one could help so I had to take her to the public toilet in A&E, whilst in there she collapsed and had another severe stroke. The result of her collapsing was DEVASTATING for me to witness.

Whilst my wife was in the Hyper Acute Stroke Unit I found myself trying to ask searching questions to doctors at her bedside as no private space was given for me to ask questions. This for me was totally inappropriate. Looking back, I wish I had asked those concerned if we could go somewhere else.... This in my view was totally unprofessional and we didn't get the full facts and severity of my wife's stroke until she went to the Evesham Rehab Unit. This left me feeling VERY DISAPPOINTED. At no point was I asked how I was coping or concerns about my wellbeing considered even though it was clear I was stressed and struggling.

My wife was suffering from severe constipation yet still the UNBELIEVABLE decision was made to discharge her to Evesham rehab unit. I did not agree that she was medically ok to be leaving the acute stroke unit, however they went ahead and discharged her at midnight to Evesham; however, she had to return to Worcester A&E within 24 hours of being at Evesham because of the severity of the pain she was in.

My wife then had to endure a five hour wait in an ambulance at A&E having been transferred from one hospital to another! My feelings when seeing my wife in pain waiting in an ambulance were ones of UTTER DISGUST, she was already in the care of the NHS, this should not have happened.

There were then a further two visits by ambulance to Worcester A&E from Evesham because of internal bleeding due to complications with the constipation. My wife was left in an ambulance for seven hours and then five hours. How is this acceptable? Transferring a patient from one hospital to another and having to wait at A&E - does no one care about their patients that are within their care? There was confusion on one occasion why she was at A&E and another issue over whether a flexible sigmoidoscopy procedure would be performed or not. We could often hear disagreements between professionals and the feeling I came away with was a LACK OF FAITH, CONFIDENCE, & TRUST.

On 25th April my wife arrived at Kidderminster Hospital by ambulance from Evesham for the flexible sigmoidoscopy procedure. She answered all the questions about why she is having the procedure perfectly. Then the question is put to her about the risks involved in the procedure and she was unable to answer these. The Sister said that the consultant carrying out the procedure was an agency one not a Trust one and therefore the patient must understand the risks. I said that I had signed the consent on behalf of my wife but that didn't count....... Unbelievable! My wife went back to Evesham without having the procedure done.

Carer Story B

I was left feeling very FRUSTRATED and ANGRY.

I have always tried to defend and support our NHS system, but what I have found within Worcestershire Acute Trust recently makes me really annoyed. Never once during the stroke period did any member of the team at the Acute Trust ask how I was, I was barely coping myself.

When I look at the team at the Evesham Rehab Unit and how they operate it is another world. They care for the patients, and they show care and compassion for the families……this is sadly not in evidence within the Acute Trust.”

Apr 2025

The Carer Advisor first met with the Carer six weeks after his wife was admitted to Worcestershire Royal Hospital, the referral was via the occupational therapist at the MDT and was classed as an urgent and complex referral due to the Carers emotional needs and concerns about Carer breakdown.

The Carer said that he and his family were “very concerned” about how he would manage when his wife is discharged home and did not feel prepared or confident in being able to provide care to his wife once discharged. He felt that his wife’s level of mobility and recovery is not where he would have liked it to be for them to feel confident and able to cope safely at home. He felt that the expectations on him to be able to manage were too high. The Carer said that he understood the intensity and demands that the caring role would have on him and recognised there would be a high risk of him not coping and at some point, breaking down. He said that he didn’t feel able to look after his own needs prior to discharge and that it was causing him to feel exhausted and anxious and very worried all the time, so it was very scary around what it would feel like after his wife has been discharged. The Carer said that he was identified as his wife’s Carer as he visits her every day on the ward, however he said that he does not feel that there has been enough communication with him around plans for his wife’s care after discharge.

> **“I am unsure who I need to approach with questions, although everyone is very nice at Evesham Hospital, I don’t know where to begin in asking questions.**

The Carer Advisor showed the Carer the Trusts **“Prepare to Care” Discharge Checklist** with a view to support him in having more meaningful conversations with the staff around his expectations and give him an opportunity to have his say and feel more involved in the discharge planning. The Carer Advisor encouraged him to request to have a discharge planning meeting, as this was his right and to take the completed checklist with him. The Carer requested a discharge planning meeting and went with his son. He was able to use the checklist to voice everything he had concerns about and to fully understand the process of discharge and what would be the things he would need to change at home to support his wife’s care.

Having the checklist along with the discharge planning meeting had a significant positive impact for the Carer, he felt more in control, enabled him to be able to think more clearly about what he needed to sort for his wife’s return and gave him confidence to start to think that they had a plan and could cope moving forward. The Carer felt that without knowing about the checklist and using it to support him with discharge planning conversations he would have continued to spiral and become increasingly anxious and stressed. He felt that every Carer should have access to this checklist to help them consider what they need to do, have conversations with staff and prioritise what needs to be done and be able to voice the impact the situation was having on him. He understood that there would need to be some significant renovations to their home to allow for his wife’s discharge to be safe. He also

Carer Story B

understood that his wife would initially have four care calls a day due to his wife requiring hoisting which greatly reduced his anxiety and allows him to have a break but also be a husband. He didn't want the discharge to feel rushed or out of control, he feels that this was understood by staff and considered.

> “I need to understand what the exact plan is, what will I need to do and what will happen in the future and will things improve.

May 2025

The Carer said that he found the Family Education Session helpful as he gained an understanding of what had happened to his wife following the stroke. He also benefited from being able to attend a physio session with his wife but did feel that more input and time would have made them both feel more confident in being able to continue this at home. Carer said that he did feel that the discharge was happening quickly and would have liked more time to ensure the house is ready but understood that his wife would be better at home and is feeling more confident that he would be able to cope once his wife is at home.

The discharge happened when it was planned for, with a delay on the day due to medication not being ready at the pharmacy.

Aug 2025

> “It's a new way of life.

After the discharge the Carer advised that everything felt completely new and that it had taken them both some time to adjust to life. With new Carers coming at all hours and the whole system of pads, catheters and the process of supply and reordering etc were unknown making the first few weeks' post discharge stressful. The Carer said that the support they received from the physio team at Evesham since discharge has been exemplary. The community stroke support team have also been proactive, especially with speech. However, his wife had not been able to benefit from much rehab due to issues with blocked catheters, UTIs and constipation which had taken up a great deal of time. The district nurses on numerous occasions have provided a wonderful service that they have both been highly impressed with.

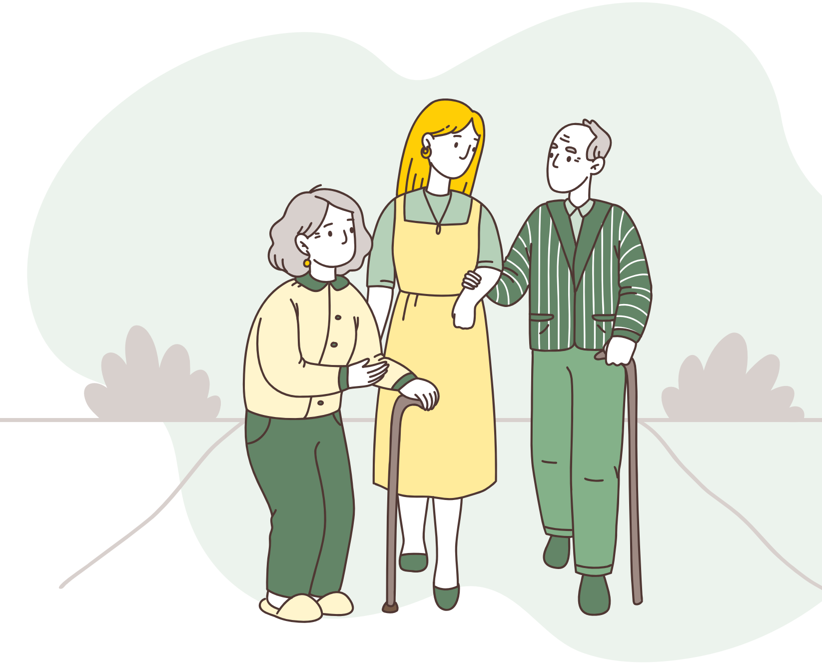
> “Those first few weeks felt like sheer chaos.

> “A discussion of all these topics prior to discharge would certainly have made the early days go far smoother and I may have slept better.

Although life looks and feels very different for them both now and despite some of the highly stressful circumstances they have experienced and navigated they are coming to terms with these changes and are moving forward with hope and feeling more optimistic about how the future looks.

> “Many people say how are you doing and I say OK. They then ask for the 'real' answer, and I can only say that we are adapting to a new way of life. Thanks to you for the great support you gave us at Evesham during the programme.

Carer Story C



Stroke Carer Case Study C - Heat Map

	Oct 2025	Nov 2025
Trauma (Not Coping) Severe Impact to Carer MH*		
Highly Stressed & Anxious (Barely Coping) High Level of Impact on Carer MH	●	●
Stressed (Coping) Sustained Impact to Carer MH		
Fluctuating Stress Some Impact on Carer MH		
No Stress and Coping - Little or no Impact on Carer MH		

*Mental Health

Background

Main Carer:
Female, Aged 77, White British, No previous ill health or admissions

Carer:
Female, Daughter to main Carer, White British, Works Part Time, Previous caring role 10 hrs per week to support Mum in her caring role

Cared For:
Male, Husband with Bowel Cancer, Carers not previously known to Carers & Communities

Carer Story C

Oct 2025

Mum (Main Carer) met with the Carer Support Advisor whist her husband was on Wyre Forest Ward. He had recently had an operation to remove part of his bowel due to bowel cancer and was awaiting discharge. He will now be living with a stoma. The Carer was concerned that the discharge was being rushed and that there had not been a home visit planned for the OT's to assess the safety at home. The Carer said that she was having to rush to get the house ready and was told that she needed to move furniture around to accommodate equipment for her husband. The Carer was feeling exhausted and overwhelmed and felt that the staff on the ward were not taking her views into consideration regarding the discharge.

The day before her husband's discharge was due to happen the Carer was moving some furniture and began to feel unwell and fell to the floor. She called her daughter who called an ambulance, however due to significant delays 111 advised that the daughter should take Mum to Worcestershire Royal A&E department. The fall had resulted in her Mum bleeding from the back passage which she was now requiring further tests for.

The daughter expressed that she felt her Mum had had a fall due to the unnecessary stress and pressure she was feeling under with her husband's imminent discharge, with visiting him each day and the pressure of getting everything ready she had run herself into the ground trying to prepare, with no support being offered or understanding from the ward staff she had become unwell and had had a fall.

The daughter said that the discharge of her Dad was meant to be the following day but with Mum now in hospital didn't see how this could happen, she said that it would be unsafe for him to go home on his own, although he would be having 4 care calls a day and be advised to stay in bed she knows this would not work and was concerned for his safety between the care call times. She went on to add that with her juggling work, her own recovery needs, visiting her Mum in hospital and her own family she would not be able to provide him with the level of care and support he would need.

The daughter did not feel that the staff at WRH or at WF Ward were taking the complexity seriously and were brushing over the risks involved and providing no reassurance or solutions. This was causing the daughter to feel very stressed and anxious and felt under a lot of pressure. Even when she was having conversations with staff she felt very disappointed that her concerns were going unheard. She felt that both herself and her Mum were being overlooked as Carers or that as patients themselves their own needs were not being considered alongside their caring roles.

> **Dad is having 4 care calls a day but it will be an unsafe situation with Mum not there.**

> **I have recently had a procedure myself and am still recovering, I have a family and a job that I am also trying to juggle.**

The daughter added that when her Mum (Main Carer) is discharged she will not take time to rest and recover herself, she will not put her own needs first and will continue to care for her dad, which will only lead to further stress and issues.

The Carer Advisor had raised the concerns

Carer Story C

around the risk of discharge to the OT on the WF Ward, reiterating that the patient was the Main Carer at home and would be discharged into a more burdensome caring role as well as requiring time to recover from her own hospital admission, but this was largely dismissed. The Carer Advisor also advised that no one from either hospital setting had considered the safety at home for either patient fully and that she understood from the daughter there were significant worries around the bathroom, there were trip hazards and no rails at the home. The OT had requested that the daughter send in some photos of the home to see the suitability and safety and had advised that a home visit would be made but this never happened. There was no mention of a pendant alarm being put into place for Dad on his discharge, this was picked up by the Carer Advisor who ensured that this was in place prior to the discharge which provided the Daughter with some relief that this would support her dad's discharge and her not feel guilty for not being there all the time.

The Carer Advisor was able to provide emotional support, information and education on falls prevention, Benefits and applying for Attendance Allowance, Information on support from social care, Assistance with applying for a Blue Badge, Carers Emergency Card. The Daughter felt reassured that the Carer Advisor understood her concerns and felt that she had been listened to and been given the time for things to be explained properly and had a better sense of how the discharges should happen.

Nov 2025

On follow up with the Daughter she explained that Dad's discharge did go ahead with her Mum still in hospital, she was distressed as he was discharged with no information around how to care for his stoma bag and it was only when she contacted the WF Ward two weeks later that information and guidance was given, she feels that he was discharged and forgotten about and no care or consideration was given to him once he was back at home.

> **I doesn't feel like his discharged was safe or planned we were largely ignored and kept out of any decisions about it.**

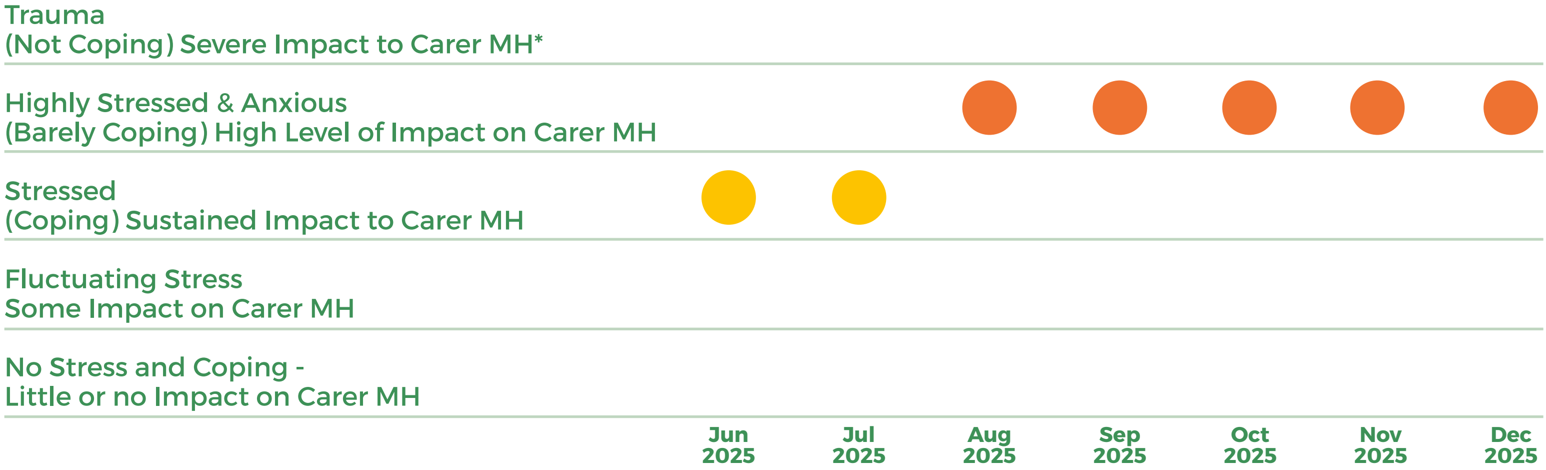
She also said that when her Mum was discharged it was a "nightmare", the discharge was unnecessarily delayed, Mum was taken off the ward in the morning and told that they needed the bed and was left there until 7.30pm after waiting all day for her medications to be dispensed from the pharmacy.

The process around reablement was very unclear for them all and were left with no understanding of what would happen once they were no longer involved. The Carer Advisor explained the process and if a package care would not be put into place what other support options would be available for them going forward.

The Daughter said that the whole situation left them all feeling drained as it had been two months of feeling stressed and anxious fighting the system and were glad things had settled down and were grateful for the support that had been offered at such a difficult time.

Carer Story D

Stroke Carer Case Study D - Heat Map



	Jun 2025	Jul 2025	Aug 2025	Sep 2025	Oct 2025	Nov 2025	Dec 2025
Trauma (Not Coping) Severe Impact to Carer MH*							
Highly Stressed & Anxious (Barely Coping) High Level of Impact on Carer MH			●	●	●	●	●
Stressed (Coping) Sustained Impact to Carer MH	●	●					
Fluctuating Stress Some Impact on Carer MH							
No Stress and Coping - Little or no Impact on Carer MH							

*Mental Health

Background

Carer:
Male, Aged 84, Husband, White British,
Has Prostate Cancer

Cared For:
Female, Aged 83, Parkinsons, Diabetes, Frailty and falls risks
No other support near by
Carer not previously known to Carers & Communities

Carer Story D

Jun 2025

Wife was admitted to Worcestershire Royal A&E via ambulance following falls in the kitchen and a cut to her head. Carer has been caring for his wife for over 3 years following the first hospital admission due to a fall and broken hip, there have been 2 futher admissions due to falls. They were known to social care and were starting a local authority funded care package for 2 calls per day which were due to start on the day of this admission. They were also known to the GP and District Nurse Team. The Carer was not known to Carers & Communities and had not been referred previously by any professionals for Carer support.

The Carer said that initially he felt relieved his wife was now in hospital and he felt optimistic that they would be able to cope once the discharge happened. He said he felt his wife's needs were increasing and that she thought her capabilities were higher than they were. Although the Carer was feeling anxious, he advised that he thought he could cope with looking after his own needs as well as his wife's once she was back home.

He said that everything had been explained to him by Ray the Ward Manager about what to expect and what would happen for discharge and he was able to ask questions. Ray had arranged for the Carer Advisor to speak with him which he found helpful as well as the OT. Both took the time to listen to his concerns and talk to him about the equipment that would need to be put into place and what other things could be helpful. He said he felt all 3 staff showed their concern for him and how he would cope. He agreed to having a pendant alarm and was able to set that up at home before his wife was discharged. This was reassuring and gave him some confidence especially due to the amount of falls his wife was having. He was also advised that the care package was increasing to 3 calls a day which added to his relief.

> **I feel with the support I have had I can cope.**

> **I feel heard and have been able to discuss things with Ray.**

The Carer Advisor provided the Carer with the following information and support –
Key Safe, Data Link Pot, Replacement Care, Carers Assessment, Benefits, TECS, Blue Badge, Falls Prevention Information.

> **TECS has really made me feel a bit more confident for the discharge to happen.**

This discharge went smoothly; everything was in place ahead of time and the Carer felt confident and ready. The Carer said that only one thing would have been helpful and that was being shown how to the use the equipment safely. It had been delivered to their home and set up but there were no instructions or demonstrations on how to use it. He had to work it out for himself once his wife was home.

Carer Story D

Aug 2025

Cared For was readmitted to the acute hospital onto the Frailty Ward with reduced mobility and a fall. He said that there had been a significant increase in the number of hours he was now caring for his wife, it had gone from about 10-20 per week, to between 40-50 hours per week just prior to this admission; he was exhausted and stressed and now feeling like he was unable to manage at home, he was not able to get a break and no respite care was in place. The District Nurses and care agency carers were coming in but it was not making any difference to the impact the caring was having on the Carer. He said that,

> I am unable to leave the house and go to my own GP appointments.

Late Aug 2025

His wife was readmitted a few weeks later but to a different ward following two falls. The Carer contacted the Carer Advisor and explained that there had been significant decline with his wife's health and mobility and he had told the district nurses, care agency Carers and now the ward staff that he was not coping with his wife's level of care needs and night times had now become very difficult and stressful. He was very tired and worried about what would happen and wanted to talk to social services about his wife going into a care home. He felt that the staff on the ward were not helpful and didn't want to listen to his concerns.

The Carer Advisor spoke to reablement who were going to be doing a re-assessment on discharge and discussed the Carers concerns and his own needs. Night time sits were discussed as well as an assessment for replacement care to give the Carer the opportunity to have a proper break. He was continuing to visit his wife in hospital everyday for long periods at a time, which meant he was not getting any time for rest himself. The Carer Advisor encouraged him to take some time away from the hospital as respite to look after himself. The Carer felt that he needed to be in the hospital with his wife so he knew what was happening with her care. The Carer later advised that no changes to the package of care were made following the Carer Advisors call or when he voiced his concerns himself.

Oct – Dec 2025

There were several other admissions over the course of a few months, these had accumulated for the Carer and become a sustained stressful and a deeply disturbing time for him. He had become disillusioned with the system and retreated from any kind of support, he felt that every way he turned there was no real care or support for his wife and he had become frustrated with telling professionals over and over again that he was not coping. The final admission to hospital was in December 2025, the Carer advised the Carer Advisor that they were waiting for an Intensive Assessment & Rehabilitation Bed but he felt that this was all probably too late, he was already exhausted and felt that his wife's care had been left to get to a point where there would be no quality of life for her.

Sady the Carers wife passed away beginning of February.

Thank you

If you have any questions or would like to discuss the recommendations, please contact :

Mel Smith
e : msmith@carersworcs.org.uk

Kim Terry
e : kterry@carersworcs.org.uk

Carers & Communities
Polysec House, Hindlip Lane,
Worcester WR3 8TJ.
Helpline: **0300 012 4272**
www.carersandcommunities.org.uk

*Carers & Communities is a working name of Worcestershire Association of Carers.
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